

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01547

1567

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 13 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Bloomingdale Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine L. Adams		4. DATE OF DEATH February 5, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Blucher		14. MOTHER'S MAIDEN NAME Susie Sours	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-2237 D	
17. INFORMANT Mrs. Charles Henn, Sr.		Address 4 Bloomingdale Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) Hypertension DUE TO (c) Degenerative Heart Disease INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 58 to 2/5/60 , that I last saw the deceased alive on 2/4/60 , 19 60 , and that death occurred at 320A, M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.E. McGrath		DATE SIGNED 2/6/60	
PHYSICIAN'S NAME (Type) W.E. McGrath M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd., Catonsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/60	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Caroline J. 1328 Sulphur Spring Rd.		24a. REC'D BY REGISTRAR FEB 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON ONE 10

10448

NAME OF DECEASED (Print name in full)		SEX (Male or Female)	
DATE OF BIRTH (Month, Day, Year)		PLACE OF BIRTH (City, State, Country)	
OCCUPATION (If any)		MARITAL STATUS (Single, Married, Widowed, Divorced)	
CAUSE OF DEATH (Immediate cause)		UNDERLYING CAUSE (If different from immediate cause)	
PLACE OF DEATH (Home, Hospital, etc.)		TIME OF DEATH (Hour, Minute)	
SIGNATURE OF PHYSICIAN (If death occurred in hospital or nursing home)		SIGNATURE OF REGISTRAR (If death occurred at home)	
SIGNATURE OF WITNESS (If death occurred at home)		SIGNATURE OF DECEASED (If death occurred in hospital or nursing home)	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1565 CERTIFICATE OF DEATH

01549

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 32 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Baltimore	
f. STREET ADDRESS 222 Endsleigh Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOSS Middle M. Last ARNOLD		4. DATE OF DEATH Month February Day 26 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1923
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 36 Days 26 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Block Operator		13. KIND OF BUSINESS OR INDUSTRY Railroad	
14. BIRTHPLACE (State or foreign country) Baltimore, Maryland		15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. FATHER'S NAME William M. Arnold		17. MOTHER'S MAIDEN NAME Clara Potter	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		19. SOCIAL SECURITY NO. 217-18-9445	
20. INFORMANT Clin. Records, VAH Balto. 18, Md., Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE 201x <input checked="" type="checkbox"/> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) REGURGITATION JAUNDICE <input checked="" type="checkbox"/> (c) EDEMA OF THE LUNGS <input checked="" type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that xx (this hospital) attended the deceased from January 25, 1960 , to February 26, 1960 , that xx (we) last saw the deceased alive on February 26, 1960 , and that death occurred 8:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE Charles Allen,		22b. DATE SIGNED 2/28/60	
22c. PHYSICIAN'S NAME (Type) CHARLES ALLEN, M.D.		22d. ADDRESS VAH Balto. 18, Md., Ft. Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/2/60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig		25a. REC'D BY REGISTRAR DATE FEB 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

JOHN HERWIG FUNERAL HOME, 2024 ORLEANS ST., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01550

1570 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN lb 22 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3446 Keswick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle W. Last BABYLON				4. DATE OF DEATH Month FEBRUARY Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 7, 1912	
9. AGE (In years lost birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Helper				10b. KIND OF BUSINESS OR INDUSTRY Trucking Firm		11. BIRTHPLACE (State or foreign country) Westminster, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Raymond H. Babylon				14. MOTHER'S MAIDEN NAME Margaret Fritz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. 218-09-1829			
17. INFORMANT Clin. Records, VAH, Balto 18, Md. Ft. Howard. Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) HYPERTENSIVE HEART DISEASE DUE TO (c) UREMIA, CHRONIC, SECONDARY TO GLOMERULONEPHRITIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 25, 1960 , to February 26, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive and February 26, 1960 , and that death occurred at 12:14 PM from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert				22b. DATE SIGNED 2-26-60			
22c. PHYSICIAN'S NAME (Type) John D. Talbert				22d. ADDRESS M.D. VAH Baltimore Md - Ft Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/1/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan				25a. REC'D BY REGISTRAR MAR 1 '60		25b. REGISTRAR'S SIGNATURE Austin E. Donovan	
ADDRESS 3818 Roland Ave Balto. 11, Md							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

01551

1571

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 919 Marksworth Rd.		d. STREET ADDRESS 919 Marksworth Rd.	
3. NAME OF DECEASED (Type or print) First MARSHALL Middle E. Last BARGER		4. DATE OF DEATH Month Feb. Day 9 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1896
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown Hightman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Address Mr. Harold W. Good - 919 Marksworth Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) Arteriosclerotic CVD- DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 8, 1957 , to Feb 9, 1960 , that I last saw the deceased alive on Feb 8, 1960 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kennard Yaffe		ADDRESS (Street, city or town, state) 5501 Forest Park Ave. Balto 7, Md.	
PHYSICIAN'S NAME (Type) KENNARD YAFFE M.D.		DATE SIGNED FEB 9 '60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/9/60	22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park	22d. LOCATION (City, town, or county) (State) Frederick, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Feete Funeral Home - Brunswick Md		24a. REC'D BY REGISTRAR FEB 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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01552

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 1572 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington - Mr. Arbutus</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>800 Warwick Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington - Mr. Arbutus</u> d. STREET ADDRESS <u>800 Warwick Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martin J. Barry, (Marcyonas J. Miezes)</u> First Middle Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Lithuanian</u>	
13. FATHER'S NAME <u>Lawrence Mieze</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212 03 9324</u>	
17. INFORMANT <u>A. Veronica Barry</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
(State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.		DATE SIGNED <u>Feb. 7, 1960</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		24a. REGISTERED BY REGISTRAR <u>FEB 11 1960</u>	
ADDRESS <u>4107 Wilkens Avenue</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b Cockeysville, Md. X		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Warren Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellen		Middle Alberta		Last Barron		4. DATE OF DEATH Month Feb.		Day 21	
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1876		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Freeland				14. MOTHER'S MAIDEN NAME Annie Nace					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Herbert F. Barron, Warren Rd.		Address Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension - DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs. unk									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-3, 1958, to 2/21, 1960, that I last saw the deceased alive on 2-20, 1960, and that death occurred at 9:30 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Bennett A. Stock				ADDRESS (Street, city or town, state) 19W Seminary Ave Cockeysville, Md.					
PHYSICIAN'S NAME (Type) Bennett A. Stock				DATE SIGNED 2/22/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 60		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Phoenix, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc. 1050 York Rd. #4				24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE Charles E. Howard			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01554

1574

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LLOYD Middle C. Last BARTGIS				4. DATE OF DEATH Month February Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster				10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Myersville, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Albert W. Bartgis				14. MOTHER'S MAIDEN NAME Lydia Blickenstaff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 220-16-0554		17. INFORMANT Clin. Records VAH Balto. 18, Md., Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TRANSITIONAL CELL CARCINOMA OF THE RIGHT URETER 180X DUE TO WITH WIDESPREAD METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 9 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that MD (this hospital) attended the deceased from February 15 1960 to February 20 1960 , that I (we) last saw the deceased alive on February 20 60 , and that death occurred 12:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Joseph J. Cillo				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/20/60	
22c. PHYSICIAN'S NAME (Type) JOSEPH J. CILLO, MD				22d. ADDRESS VAH Balto. 18, Md., Ft. Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-24-60		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City, town, or county) _____ (State) _____ Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss Taneytown, Md.				25a. REC'D BY REGISTRAR DATE FEB 23 60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

FUSS FUNERAL HOME, TANEYTOWN, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1934

Deceased

Birthplace

Age

Sex

Color

Place of Birth

Place of Death

10-300

1934

Deceased

Sex

Color

Age

Place of Birth

Sex

Color

Place of Death

10-300

1934

Deceased

Birthplace

Age

Sex

10-300

1934

Deceased

10-300

1934

Deceased

10-300

1934

Deceased

10-300

1934

Deceased

10-300

1934

Deceased

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1575 CERTIFICATE OF DEATH

Reg. Dist. No.

02881

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Reisterstown Road	
3. NAME OF DECEASED (Type or print) First Marie Middle Loretta Last Batz		4. DATE OF DEATH Month February Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Pikesv. Movies	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George C. Batz		14. MOTHER'S MAIDEN NAME Loretta B. Dyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-3151	
17. INFORMANT Mrs. Helen Moser		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 18, 1960 , to February 23, 1960 , that I last saw the deceased alive on February 18, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clare E. McWilliams		ADDRESS (Street, city or town, state) Reisterstown, Maryland	
PHYSICIAN'S NAME (Type)		DATE SIGNED February 23, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 26, 1960	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Hemmell		24. REC'D BY REGISTRAR MAR 29 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1275 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1275

1

1

1561 CERTIFICATE OF DEATH

01555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Lansdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 358 Bigley Ave.		d. STREET ADDRESS 358 Bigley Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Lewis Last Baughner		4. DATE OF DEATH Month 2/22/60 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Lewis		14. MOTHER'S MAIDEN NAME Mary Ann MacFadden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Alice Elliott 358 Bigley Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH. 20 min. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1 , 19 60 , to Feb. 22 , 19 60 , that I last saw the deceased alive on Feb. 21 , 19 60 , and that death occurred at 8 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris W. Steinberg		ADDRESS (Street, city or town, state) 3913 Hollins Ferry Rd. DATE SIGNED 2/22/60	
PHYSICIAN'S NAME (Type) Dr. Morris W. Steinberg		3913 Hollins Ferry Rd.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/24/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 29	
24a. REC'D BY REGISTRAR FEB 24 '60		DATE 2/24/60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Baltimore

Longwood

303 E. 1st Ave.

2 0240

11-6-1971

Mr.

Mr. and Mrs. [illegible]

Mr. [illegible] 35 [illegible] Ave.

John

313 Holliston Terrace, Md.

Bellevue, Md.

Donson Park Lane

27-100

Serial

Howard N. [illegible] 1107 [illegible] St. S.E.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1576

Reg. Dist. No.

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oliver Beach (20)

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

54 Oliver Beach (20)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Box 215 Gunpowder Rd.

d. STREET ADDRESS

Box 215 Gunpowder Rd.

e. IS RESIDENCE
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

MARY RACHEL BAYMAN

4. DATE
OF
DEATH

Month

Day

Year

February 21,

19 60

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

Nov. 1, 1868

9. AGE (In years
last birthday)

91

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jobez Oldroyd

14. MOTHER'S MAIDEN NAME

Martha Worthington

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)

No

--

16. SOCIAL SECURITY NO.

159-18-2886A

17. INFORMANT

Address

William Gee 210 Mill Rd. Mt. Holly N.J.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

450.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.

19

20d. INJURY OCCURRED
While
at work ☐ Not while
at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Jack O. Collins

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

2-21-60

EXAMINER'S
NAME (Type)

Jack O. Collins

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

22b. DATE THEREOF

2/21/60

22c. NAME OF CEMETERY OR CREMATORY

Greenmount Cemetery

22d. LOCATION (City, town, or county)

Phila., Pa.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James Bruzdinski 1407 Eastern Ave.

24a. REC'D BY REGISTRAR

DATE FEB 23 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. K...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 70
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1938

DATE OF DEATH
1938

MARRIAGE

AGE
SEX
RACE
RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

TOXIC SUBSTANCE

INSTRUMENTS

OPERATION

POST-MORTEM

LABORATORY

TOXICOLOGY

ANTHROPOLOGY

PHYSIOLOGY

PATHOLOGY

BACTERIOLOGY

VIROLOGY

IMMUNOLOGY

GENETICS

PHARMACOLOGY

PHYSICS

CHEMISTRY

METALLURGY

MINERALOGY

ZOOLOGY

ENTOMOLOGY

ORITHOLOGY

ICHTHOLOGY

MALACOLOGIA

CONCHIOLOGY

MOLLUSCOLOGY

CRUSTACEOLOGY

COELOPODIOLOGY

CHITINOLOGY

ARTHRALGOLOGY

MYCOLOGY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01557

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> <u>1577</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Chir</u> b. COUNTY <u>Richland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Transfield</u> <u>72X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Liberty Road</u>		d. STREET ADDRESS <u>1822 Woodville Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>VERNON (WEALKER) BEALL</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15, 1903</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Rm. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telaware Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lesington W. Beall</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-10-5048</u>	
17. INFORMANT <u>Mildred Lee Rizer</u>		Address <u>Randallstown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes</u> (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>none</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Brethren Cem.</u>
22d. LOCATION (City, town, or county) <u>Flintstone, Maryland</u>		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
		24b. REGISTRAR'S SIGNATURE _____	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1578 CERTIFICATE OF DEATH

Reg. Dist. No.

01558

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>6 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 Bishops LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CAROLINE</u> Middle <u>P.</u> Last <u>BELL</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 21, 1884</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING Mfg.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Tiller</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Sadler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. WESLEY OREM</u>		Address <u>1 Bishops LANE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> , 19 <u>40</u> to <u>2-22-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-22-</u> , 19 <u>60</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris B. Schreiber</u>		ADDRESS (Street, city or town, state) <u>54 S. F. N. Ave.</u> DATE SIGNED <u>2-23-60</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS B. SCHREIBER</u>		<u>Baltimore Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u>		ADDRESS <u>Francis W. Miller 2101 Frederick Ave.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	

01358

1918

[Faint, illegible text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01559

1579 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>55</u> <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>221 Rogers Forge Rd.</u>		d. STREET ADDRESS <u>221 Rogers Forge Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hollis</u> Middle <u>F.</u> Last <u>Bennett</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metals</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Cleophus E. Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Collison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-4160</u>	
17. INFORMANT <u>Mrs. Louise C. Bennett</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>8-8-59</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-4-1958</u> to <u>2-9-1960</u> , that I last saw the deceased alive on <u>2-9-1960</u> , and that death occurred on <u>5:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Siver</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3105 N. Charles St. Baltimore, Md. 2-10-60</u>	
PHYSICIAN'S NAME (Type) <u>R.H. Siver</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd. Baltimore 12, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of the person or organization to whom the letter is addressed.

2. Address of the person or organization to whom the letter is addressed.

3. City, State, and Zip Code of the person or organization to whom the letter is addressed.

4. Date of the letter.

5. Salutation (e.g., Dear Sir, Dear Madam, Dear Mr. Smith).

6. Body of the letter (the main text).

7. Closing (e.g., Sincerely, Very truly yours, Respectfully).

8. Signature of the person sending the letter.

9. Name and Title of the person sending the letter.

10. Address of the person sending the letter.

11. City, State, and Zip Code of the person sending the letter.

12. Enclosures (if any).

13. Postage (if any).

14. Return address (if any).

15. Other information (if any).

1580 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 6yr10mth28dys		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		
f. STREET ADDRESS 3711 West Strathmore Avenue			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Sarah Middle Last Bercowitz			4. DATE OF DEATH Month FEBRUARY Day 2 Year 1960		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec., 1906		9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Abraham Bercowitz		
14. MOTHER'S MAIDEN NAME Rachael Edelberg			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		
16. SOCIAL SECURITY NO. Unknown			INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arterioscl. general, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Jan. 10, 1960 , to FEB. 2, 1960 , that I last saw the deceased alive on FEB. 2, 1960 , and that death occurred at 5:45 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Stella Wachslar M.D.			ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		
PHYSICIAN'S NAME (Type) STELLA WACHSLER			Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/60		22c. NAME OF CEMETERY OR CREMATORY Baldwin	
22d. LOCATION (City, town, or county) (State) Baldwin, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Bob Levenson		24a. REC'D BY REGISTRAR FEB 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1120 CERTIFICATE OF DEATH

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10

0830

Feb 3 1941

Feb 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01561

1581 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN Tb 1 year 3m, 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ola Middle May Last Biddinger		4. DATE OF DEATH Month February Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1886 1885 XXXXX
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Unknown Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown Abraham Rickmond		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 28, 1958 to Feb. 3, 1960 , that I last saw the deceased alive on Feb. 3, 1960 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-4-60			
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-6-60	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	22d. LOCATION (City, town, or county) (State) Ellicott City, Md
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thoma		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1961 CERTIFICATE OF DEATH

2-11-1961

100-10-016

0160000

Blank form with faint lines and text, including a large vertical stamp on the left side.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1582 CERTIFICATE OF DEATH

01562

32

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balt.</u> City <u>✓</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson, Maryland</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		<u>3V01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>22 S. Athol Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry Lee Billmyer</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 15 19 60</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/3/73</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>building</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Oliver Billmyer</u>				14. MOTHER'S MAIDEN NAME <u>Frances Lavenia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none 220-30-2872A</u>		17. INFORMANT & ADDRESS <u>Hospital Records, Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>15 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>002X Pulmonary tuberculosis</u>						<u>3 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/9/57</u> , 19 <u>57</u> , to <u>2/15/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/15/60</u> , 19 <u>60</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D.</u>				ADDRESS (Street, city, town, state) <u>Superintendent, Mt. Wilson, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB. 18/60</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 17 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral City</u>		ADDRESS <u>4101 EDMONDSON AVE.</u>	

1. *Phragmites* (Common Reed)

1583 CERTIFICATE OF DEATH

Reg. Dist. No. 01563

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova c. LENGTH OF STAY IN 1b 3 Y 01-4 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home, 6811 Campfield Rd		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 639 N. Augusta Ave d. STREET ADDRESS 639 N. Augusta Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard T. Birchett		4. DATE OF DEATH Month Day Year Feb. 6/60 19	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Butcher		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard T. Birchett		14. MOTHER'S MAIDEN NAME ---Barringer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. George Forsythe, 619 N. Augusta Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) - Anterior Sclerotic Heart Disease 481X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) (2) - Influenza DUE TO (c) Generalized Anterior Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March - 3, 1959 to Feb 6, 1960 that I last saw the deceased alive on Feb 5, 1960 , and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts. Balto - 7 md 26 60	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE 4108 Liberty Hts. Balto - 7 md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 8/60	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.		24a. REC'D BY REGISTRAR DATE FEB 11 '60	
ADDRESS 4101 Edmondson Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Henshaw	

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

01583

1583

Baltimore

Villa Nova

Argentine House, 8811 Campbell Rd. 830 N. Avenue Ave

Feb. 6/60

Richard T. Birchett

37

March 12, 1875

Baltimore, Md.

--- Baltimore

Richard T. Birchett

Richard T. Birchett

Mrs. George Forsythe, 819 N. Avenue Ave.

Baltimore, Md.

April 1875

Feb. 6/60

April

1875 N. 6121 Thompson Ave

1531 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>144</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 KING CT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First Middle Last <u>Black</u>		4. DATE OF DEATH <u>February 10</u> Month Day Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-15-99</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>5</u> Hours <u>-</u> Min <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labort</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>	
11. BIRTHPLACE (State or foreign country) <u>Fairfield S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andy Black</u>		14. MOTHER'S MAIDEN NAME <u>Mary Thicker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-735</u>	
17. INFORMANT <u>MARIE OWENS</u> Address <u>14318 Sager St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Nephritis</u> (c) <u>Coronary-Vascular Disease (Atherosclerosis)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hr.</u> <u>2 MONTHS</u> <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 4, 1948</u> , to <u>FEB 10, 1960</u> , that I last saw the deceased alive on <u>FEBRUARY 10, 1960</u> , and that death occurred at <u>7:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade</u> M.D.		ADDRESS (Street, city or town, state) <u>140 Oak Ave</u> DATE SIGNED <u>2-10-60</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/13/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas C. Wilson</u> ADDRESS <u>1000 Brantley Ave</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G257 2-26-60 et
1584 CERTIFICATE OF DEATH

01565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 S. Rolling Rd. (At home)		d. STREET ADDRESS Dixon Hill	
3. NAME OF DECEASED (Type or print) First HILDA Middle S. Last BOOZE		4. DATE OF DEATH Month Feb. Day 20 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Steinbach		14. MOTHER'S MAIDEN NAME Mary Reinhardt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. William C. Booze - 906 Locustvale Rd.		Address Towson, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum with metastases 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Nov '57
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 5 Feb , 1960, to 20 Feb , 1960, that I last saw the deceased alive on 20 Feb , 1960, and that death occurred at 11:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St. DATE SIGNED 2-22-60			
ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D.		PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. Baltimore 2, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/23/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fisher - 1118 St Paul St.		24a. REC'D BY REGISTRAR DATE FEB 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

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1585 CERTIFICATE OF DEATH

Reg. Dist. No.

01566

1. PLACE OF DEATH <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/>			
a. COUNTY <u>Baltimore</u> MARYLAND				o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>4 years.</u>				d. STREET ADDRESS <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Georgianna</u> Middle <u>Bowen</u> Last <u>Bowen</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1909</u>	
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>51</u> Days <u>1</u> Hours <u>19</u> Min. <u>60</u>		IF UNDER 24 HRS. Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jim Bowen</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Rosewood Records</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>490X</u> DUE TO <u>Pneumonia, lobar</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>4 days</u> (c) <u>4 hours</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/10/56</u> , 19 <u>56</u> , to <u>2/1/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/1/60</u> , 19 <u>60</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Rosewood State Training School</u> DATE SIGNED <u>2/5/60</u>							
ACTUAL SIGNATURE <u>Edward J. Mathews</u> M.D. <u>Rosewood State Training School</u> <u>2/5/60</u>							
PHYSICIAN'S NAME (Type) <u>Edward J. Mathews, M.D.</u> <u>Owings Mills, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>2-5-20</u>		<u>2-5-20</u>		<u>St. Mary's Cemetery</u>		<u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u> ADDRESS <u>12300</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>FEB 18 '60</u>		<u>Charles S. Kenna</u>	

Page death. The law requires that the death certificate be executed within 24 hours of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PIAZZO STAFFORD

1586

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01567

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edmonsville</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>090 1000 York Low Home</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Balto.</i> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Logwood Rd.</i> d. STREET ADDRESS <i>Woodlawn 7</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Adelaide S. Bowers</i> First Middle Last S. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>9/30/84</i> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <i>75</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <i>Feb. 17 1960</i> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i> 11. BIRTHPLACE (State or foreign country) <i>Ind.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Geo. Schuman</i> 14. MOTHER'S MAIDEN NAME <i>Sophia Meier</i> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <i>Ethel Wahans</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Influenza</i> DUE TO <i>481X</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>arteriosclerotic cardiovascular disease</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Paralysis agitans</i> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> 19 <i>Feb 17</i> 1960, that (I) (we) last saw the deceased alive on <i>Feb 16</i> 1960, and that death occurred at <i>12:10</i> AM, from the causes and on the date stated above. 22a. SIGNATURE <i>John A. Nesbitt Jr.</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <i>JOHN A. NESBITT, JR</i> 22d. ADDRESS <i>1118 St Paul St., Baltimore 2, Ind.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>2/20/60</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Toulong Park</i> 23d. LOCATION (City, town, or county) (State) <i>Balto. Ind.</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Mac Galt & Son</i> ADDRESS <i>28</i> 25a. REC'D BY REGISTRAR <i>FEB 23 '60</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. King</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

2

3

4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1587

CERTIFICATE OF DEATH

01568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville 8</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>112 Walker</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Alverta</u> Last <u>Bowersox</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29, 1880</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Adams County, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Eckenrode</u>		14. MOTHER'S MAIDEN NAME <u>Marion Monk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Orma Bowersox</u>		Address <u>Pikesville 8, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.V.D.</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ulcers of legs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 17</u> , 19 <u>60</u> , to <u>Feb 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 17</u> , 19 <u>60</u> , and that death occurred at <u>0155 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles H. Williams, M.D.</u> <u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Feb. 18, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Havel</u> ADDRESS <u>Pikesville 8</u>		24d. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

01-68

See Dist. No.

1. NAME OF DECEASED [Handwritten: [illegible]]		2. SEX [Handwritten: Male]		3. AGE [Handwritten: 60]		4. DATE OF BIRTH [Handwritten: 10/15/1908]		5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]		6. PLACE OF DEATH [Handwritten: Baltimore, Md.]	
7. OCCUPATION [Handwritten: [illegible]]		8. MARITAL STATUS [Handwritten: Married]		9. EDUCATION [Handwritten: High School]		10. RELIGION [Handwritten: Catholic]		11. CAUSE OF DEATH [Handwritten: [illegible]]		12. MANNER OF DEATH [Handwritten: Natural]	
13. DATE OF DEATH [Handwritten: 11/10/1968]		14. TIME OF DEATH [Handwritten: 10:00 AM]		15. PLACE OF DEATH [Handwritten: Home]		16. NAME OF PHYSICIAN [Handwritten: [illegible]]		17. NAME OF FUNERAL HOME [Handwritten: [illegible]]		18. NAME OF BURIAL PLACE [Handwritten: [illegible]]	
19. SIGNATURE OF DECEASED [Handwritten: [illegible]]		20. SIGNATURE OF WITNESS [Handwritten: [illegible]]		21. SIGNATURE OF PHYSICIAN [Handwritten: [illegible]]		22. SIGNATURE OF FUNERAL HOME [Handwritten: [illegible]]		23. SIGNATURE OF BURIAL PLACE [Handwritten: [illegible]]		24. SIGNATURE OF DISTRICT HEALTH OFFICER [Handwritten: [illegible]]	

1562 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>				c. LENGTH OF STAY IN 1b <i>51 Baltimore 27.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>4147 Linden Ave.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Annabelle Elizabeth Boyd</i>				4. DATE OF DEATH Month Day Year <i>Feb. 5 19 60</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-18-1900</i>	9. AGE (In years last birthday) yrs. <i>60</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Mark R. Scholl</i>				14. MOTHER'S MAIDEN NAME <i>Katherine E. Stitze</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <i>Howard Boyd</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac dilatation</i> <i>442x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Renal cardiovascular disease</i> DUE TO (c) <i>hypertension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>— 19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 19 <i>40</i> , to <i>Feb. 5</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Feb 4</i> , 19 <i>60</i> , and that death occurred at <i>4:30 P.</i> M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Alcaias</i> M.D. <i>4 N Fulton Ave Balt Md</i> ADDRESS (Street, city or town, state) DATE SIGNED <i>2/6/60</i>							
PHYSICIAN'S NAME (Type) <i>477 Fulton Ave BALTIMORE</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>2/9/60</i>		<i>2/9/60</i>		<i>PARKWOOD Cem</i>		<i>BALTO Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 9 '60</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

153

DECEASED

DATE OF DEATH

THIS DEATH WAS CAUSED BY

THE FOLLOWING DISEASE

AND

WAS ACCOMPANIED BY

ON

1-15-19

AT

TIME

AGE

SEX

RESIDENCE

DECEASED

DECEASED

AND

DECEASED

DECEASED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1588

CERTIFICATE OF DEATH

01570

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaywood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaywood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6814 Blenheim Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HESTER</u> Middle <u>HILL</u> Last <u>BOYER</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 19, 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>--</u>							
13. FATHER'S NAME <u>Charles S. Hill</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Sparks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Mrs. George Bullard - 50 Dunkirk Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>--</u> DUE TO (c) <u>--</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-31, 1959</u> , to <u>2-12</u> , 1960, that I last saw the deceased alive on <u>2-12</u> , 1960, and that death occurred at <u>12:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William G. Helfrich</u>				ADDRESS (Street, city or town, state) <u>5006 Roland av</u> DATE SIGNED <u>2-14-60</u>			
PHYSICIAN'S NAME (Type) <u>Balto 10, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto 17</u>				ADDRESS <u>md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

CERTIFICATE OF DEATH

1968

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		DATE	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

1 **1** **8**
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1589 CERTIFICATE OF DEATH

01571

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Codd Nursing Home				d. STREET ADDRESS 55 Towson 512 Woodbine Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First VIOLA Middle STOLL Last BRACKEN				4. DATE OF DEATH Month February Day 22 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1875	
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Augustus Stoll				14. MOTHER'S MAIDEN NAME Caroline Sauter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Francis Pettijohn, Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerosis, family DUE TO (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 7 days 5 yrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11:00 AM 1960 to 2:25 PM 1960 , that (I) (we) last saw the deceased alive on 16/16 1960 , and that death occurred at 4:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Howard H. Burns				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) How				22d. ADDRESS 6601 Laurel Rd Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Feb. 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Walter Frey Funeral Home		23d. LOCATION (City, town, or county) (State) Lorraine, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				ADDRESS		25a. RECEIVED BY REGISTRAR DATE FEB 26 1960	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01572

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1590

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BACK RIVER NECK</u>		c. LENGTH OF STAY IN lb <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BACK RIVER NECK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>822 BACK RIVER NECK ROAD</u>				d. STREET ADDRESS <u>822 BACK RIVER NECK ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>W</u> Last <u>BREHM.</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 3, 1872</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN HENRY BREHM.</u>				14. MOTHER'S MAIDEN NAME <u>JEANETTE LAWRENCE.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS AMANDA BREHM 822 BACK RIVER NECK RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm:</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO</u> <u>MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Funeral Home</u>				ADDRESS <u>17401 Belair Rd #6</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>FEB 15 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>		DATE SIGNED <u>2/13/60</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M X 1 0 BP VS A15 (4) 15M 9/58 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 1591 18 01573 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3004 Woodside Avenue 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3004 Woodside Avenue e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY BRETHHOLL 4. DATE OF DEATH February 3, 1960 5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH Sept. 29, 1887 9. AGE (In years last birthday) yrs. 72 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Machinist Retired Baltimore, Maryland USA 13. FATHER'S NAME Henry Brettholl 14. MOTHER'S MAIDEN NAME Amelia Battenfield 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. none INFORMANT Address Mrs. Anna M. Brettholl-3004 Woodside Ave. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 CARCINOMA, Left main bronchus, UNdifferentiated, sub-carinal Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from July 22, 1957, to Feb 3rd, 1960, that I last saw the deceased alive on Feb 2nd, 1960, and that death occurred at 5:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE W.M. Conway M.D. ADDRESS (Street, city or town, state) 8358 Loch Raven Blvd, Baltimore, Md. DATE SIGNED 2/4/60 PHYSICIAN'S NAME (Type) W.M. Conway M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/6/60 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. SANDER & SONS, INC., Baltimore, Md. 24a. REC'D BY REGISTRAR DATE FEB 5 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Hume

1591

CERTIFICATE OF DEATH

Reg. Dist. No.

01573

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3004 Woodside Avenue		d. STREET ADDRESS 3004 Woodside Avenue	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last BRETHHOLL		4. DATE OF DEATH Month February Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 29, 1887
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Brettholl	
14. MOTHER'S MAIDEN NAME Amelia Battenfield		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		INFORMANT Address Mrs. Anna M. Brettholl-3004 Woodside Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 CARCINOMA, Left main bronchus, UNdifferentiated, sub-carinal Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22, 1957 , to Feb 3rd, 1960 , that I last saw the deceased alive on Feb 2nd, 1960 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.M. Conway		ADDRESS (Street, city or town, state) 8358 Loch Raven Blvd, Baltimore, Md.	
PHYSICIAN'S NAME (Type) W.M. Conway M.D.		DATE SIGNED 2/4/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/60	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. SANDER & SONS, INC., Baltimore, Md.		24a. REC'D BY REGISTRAR DATE FEB 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

100-100000

CERTIFICATE OF DEED

THIS CERTIFICATE OF DEED is made this 1st day of January, 1900, at the County of [illegible] State of [illegible].
I, [illegible], County Clerk, do hereby certify that the within and foregoing is a true and correct copy of the original of record in my office.
In testimony whereof, I have hereunto set my hand and the seal of said County at the City of [illegible] this 1st day of January, 1900.

Witness my hand and the seal of said County at the City of [illegible] this 1st day of January, 1900.
[illegible]
County Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1592 CERTIFICATE OF DEATH

Reg. Dist. No.

01574

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>530 Hampton Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth E.</u> Middle <u>Breyer</u> Last <u></u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Wood</u>		14. MOTHER'S MAIDEN NAME <u>Emma</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>2215-01-36750</u>	
17. INFORMANT <u>Mrs. Milton Reynolds,</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS -</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 19, 1960</u> to <u>FEB. 25, 1960</u> , that I last saw the deceased alive on <u>2/23, 1960</u> , and that death occurred at <u>1453 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph J. Cameron</u>		ADDRESS (Street, city or town, state) <u>1515 - Martin BLVD - BALTO, 20, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH J. CAMERON</u>		DATE SIGNED <u>2/25/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

1934

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1934

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Death	
County		City	
State		Country	

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Towson d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 21 Tenbury Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 21 Tenbury Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE PHILLIP BUCK		4. DATE OF DEATH Month February Day 22 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 14 3 IF UNDER 1 YEAR: Months 14 Days 3 IF UNDER 24 HRS.: Hours 14 Min. 3
11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ronald Buck		14. MOTHER'S MAIDEN NAME Rose E. Freitas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ronald Buck, 21 Tenbury Rd., Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED 2/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Marie Cemetery		22d. LOCATION (City, town, or country) (State) Towson, Maryland	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR FEB 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2047283XV5

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At Home

Baby

10/18/2005

802

and

3. **Выводы:**

10/1/2000

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Samuel's Book, 21 January 1891, 10:00 AM.

Page 10

113

2000

John James, Boston, February 1862.

Smith, J. H. 1966. The

Dr. G. H. H. H. H. H.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01578 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson, Md.</u>				TOWN <u>Mayo Post office</u>		<u>02x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Elsie Lee Burgess</u>				<u>2 4 1960</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>2/13/1885</u>	<u>74</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>FLOYD BURGESS</u>				<u>SARAH LEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>002x</u> IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						<u>6 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/13/1959</u> to <u>2/4/1960</u> , that I last saw the deceased alive on <u>2/4/1960</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland</u>				ADDRESS (Street, city, town, state) <u>Baltimore, Md.</u>			
DATE SIGNED <u>2/8/60</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/8/60</u>		<u>All Hallows Cemetery</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 17 '60</u>		<u>Arthur S. Kraus</u>		<u>Wm. H. Hapgood</u>		<u>Annapolis, Md.</u>	
DATE							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1595

CERTIFICATE OF DEATH

Reg. Dist. No.

01577

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2505 Linwood Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Beatrice</u> Last <u>Bush</u>		4. DATE OF DEATH Month <u>2-3-60</u> Day <u>19</u> Year <u>19</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Doyle</u>	
14. MOTHER'S MAIDEN NAME <u>Mary O'Connor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>719-07-9843</u>		17. INFORMANT <u>William Daniel Bush, Sr.</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Pancreas.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Endogenous malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-6 wks.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>fall</u> , 19 <u>58</u> , to <u>2-3</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>12-29</u> , 19 <u>60</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hyle</u>		DATE SIGNED <u>7-5-27</u> <u>John C. Hyle</u>	
PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>		<u>2-4-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>	
ADDRESS <u>5305 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15577

15577



1 1 090 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 090 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1596 1596

CERTIFICATE OF DEATH

01578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3Y01.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pine</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>CAPHAN</u> Last <u>CAPHAN</u>				4. DATE OF DEATH Month <u>2</u> - Day <u>18</u> - Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>70</u> yrs.	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u> Hours <u>19</u> Min. <u>60</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bury</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Reubin</u>			
14. MOTHER'S MAIDEN NAME <u>Not known</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>Jacob Caphan - 2905 Taney Rd</u>				17. INFORMANT <u>Jacob Caphan - 2905 Taney Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Balto</u>				20g. (County) <u>Md</u>		20h. (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>Oct 19 1959</u> , to <u>Feb 18 1960</u> , that I last saw the deceased alive on <u>2-18-60</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel J. Schwartz</u> M.D. <u>2320 Eutaw Place</u>				ADDRESS (Street, city or town, state) <u>2320 Eutaw Place</u>			
DATE SIGNED <u>2/18/60</u>				PHYSICIAN'S NAME (Type) <u>Daniel J. Schwartz, M. D.</u> <u>2320 Eutaw Place</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-19-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob K. Kowalski</u>				ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Krawitz</u>							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>		<p>12. DATE OF DEATH [Faint handwritten date]</p>	
<p>13. PLACE OF DEATH [Faint handwritten place]</p>		<p>14. SIGNATURE OF WITNESS [Faint handwritten signature]</p>	
<p>15. SIGNATURE OF DECEASED [Faint handwritten signature]</p>		<p>16. SIGNATURE OF NEXT OF KIN [Faint handwritten signature]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1597 CERTIFICATE OF DEATH

Reg. Dist. No.

01579

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr 7mth 28dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Etta Middle Agnes Last Carpenter		4. DATE OF DEATH Month February Day 28 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Moran		14. MOTHER'S MAIDEN NAME Jane ? Mayberry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarctive myocardial fibrosis DUE TO (c) Arteriosclerotic cardiovascular disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30 19 58 , to Feb. 28 19 60 , that I last saw the deceased alive on Feb. 28 19 60 , and that death occurred at 2:30a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachser M.D.		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 2-29-60	
PHYSICIAN'S NAME (Type) Stella Wachser, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/3/60	22c. NAME OF CEMETERY OR CREMATORY WILLIMANTIC CEMETERY	22d. LOCATION (City, town, or county) (State) WILLIMANTIC CONN.
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc. Balto. Md.		24a. REC'D BY REGISTRAR MAR 2 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1598

CERTIFICATE OF DEATH

01580

Item 2 Film 256 2-19-60 et

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>BALTO</i> Pri. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bussell Rest Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Eva Cashell</i>		4. DATE OF DEATH <i>Feb. 6 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/20/89</i>
9. AGE (In years lost birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pract.</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Hospital records Spring Grove</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chr. Arteriosclerotic Cardio-Vascular Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i> <i>10 da.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9-30-1958</i> to <i>2-6-1960</i> , that (I) (we) last saw the deceased alive on <i>2-6-1960</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Wilmer K. Gallagher</i>		22b. DATE SIGNED <i>2-6-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, M.D.</i>		22d. ADDRESS <i>6209 Frederick Ave., Baltimore 28, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-12-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. John's</i>		23d. LOCATION (City, town, or county) (State) <i>Olney, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>		25a. REC'D BY REGISTRAR <i>FEB 12 '60</i>	
ADDRESS <i>Laytonville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles E. Kneass</i>	

11/10/00

DEPARTMENT OF DEATH

1228

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1593 CERTIFICATE OF DEATH

Reg. Dist. No.

01581

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr10mth12dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Melford Goldie Castle		4. DATE OF DEATH Month Day Year February 26 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1886
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1959 to Feb. 26, 1960 , that I last saw the deceased alive on Feb. 26, 1960 , and that death occurred at 1:00a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-26-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 29, 1960	
22c. NAME OF CEMETERY OR CREMATORY Temple Hill Cemetery		22d. LOCATION (City, town, or county) (State) Russell Co., Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Kone ADDRESS 4001 Ritchie Hwy.		24a. REC'D BY REGISTRAR DATE MAR 1 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VR A15 (4)
15M 9/59

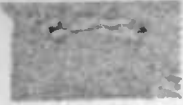
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01582

1600

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 30 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Baltimore(25) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3V01-4 d. STREET ADDRESS 1107 Edwight Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First JOHN Middle F. Last CHANEY		4. DATE OF DEATH Month February Day 8 Year 19 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Cutter		10b. KIND OF BUSINESS OR INDUSTRY Glass Factory		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Samuel L. Chaney		14. MOTHER'S MAIDEN NAME Helen E. Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 212-10-8271		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. FT. HOWARD DIV.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, STAPHYLOCOCCIC, RIGHT 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY CONGESTION AND EDEMA, BILATERAL (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgical abscess partial stomach, old. Gastro jejunostomy, old. Chronic adhesive peritonitis. Arteriosclerotic nephrosclerosis. Benign P. H.						INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT UNKNOWN
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that X (this hospital) attended the deceased from Jan. 9 19 60 , to Feb. 8 19 60 , that X (we) last saw the deceased alive on Feb. 8 19 60 , and that death occurred at 2:40AM on the causes and on the date stated above.						
22a. SIGNATURE W. J. Pijanowski		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 2/8/60		
22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D.		22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE James L. McCully		ADDRESS 237 Patapsco, Baltimore, Md.		25a. REC'D BY REGISTRAR FEB 10 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



RECEIVED
FEBRUARY 22 1951

General J. H. Dwyer
 Glass Factory
 Washington, D. C.
 U. S. A.

General J. H. Dwyer
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General J. H. Dwyer
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 U. S. A.

CHARLES

08X-2

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Year

Hours	Min.
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U. S. A.

~~Elizabeth Williams~~ Elizabeth Williams

Address

INTERVAL BETWEEN ONSET AND DEATH

GENERAL ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

ADDRESS (Street, city or town, state) DATE SIGN
SPRING GROVE STATE HOSPITAL

P. K. V. P., M.D.

(State)

Arthur S. Kraus

01553

DEPARTMENT OF HEALTH

1901

11

[Faint, mostly illegible text, possibly a form or report, with some lines underlined.]

1901-02 Old Field
Huckeyville, Ind.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1603

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balti</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balti</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balti 7, Md. 1 mo.</u>		c. LENGTH OF STAY IN 1b <u>X Balti 7, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7020 Winnsboro Mill Rd</u>			d. STREET ADDRESS <u>7020 Winnsboro Mill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROBT.</u> Middle <u>SCOTT</u> Last <u>CHELTON</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20 1960</u>		9. AGE (In years last birthday) yrs. <u>30</u> Months <u>30</u> Days <u>30</u> Hours <u>30</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Balti, Md.</u>	
13. FATHER'S NAME <u>James Chelton</u>			14. MOTHER'S MAIDEN NAME <u>Betty Lucile Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Name <u>Betty L. Chelton</u> Address <u>7020 Winnsboro Mill Rd Balti 7, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>nasal-pharyngeal - Bronchitis</u> <u>501X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH: <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u>Balti</u>		20g. (County) <u>Balti</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Feb 19, 1960</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Baltimore</u>		22e. (State) <u>Md.</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		ADDRESS <u>1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>FEB 25 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		24c. (City, town, or county) <u>Balti</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

900000000000 2031213XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND
1602
CERTIFICATE OF DEATH

01585

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>52</i> <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Caton Ridge Conv. home</i>		d. STREET ADDRESS <i>1112 Glenwood Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Carrye Christle</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/13/77</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Wm. Munch</i>		14. MOTHER'S MAIDEN NAME <i>Achwind</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Helen Harrington</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Cardiac failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis generalis</i> DUE TO (c) <i>unknown</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1</i> 19 <i>60</i> to <i>Feb 2</i> 19 <i>60</i> that (I) (we) lost the deceased alive on <i>Feb 1</i> 19 <i>60</i> , and that death occurred at <i>10:30</i> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Cliff Ratliff, Jr.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFF, JR.</i>		22d. ADDRESS <i>4605 Edmondson Ave</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/5/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Western</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. J. J. Don</i>		24. ADDRESS <i>28</i>	
25a. REC'D BY REGISTRAR DATE <i>FEB 8 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>	

1917

CERTIFICATE OF DEATH

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1604 CERTIFICATE OF DEATH

Reg. Dist. No.

01586

1. PLACE OF DEATH a. COUNTY Towson <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore <i>4- Towson</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 Murdock Road				d. STREET ADDRESS 110 Murdock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph G. Cincotta				4. DATE OF DEATH Month Day Year Feb. 17 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1912 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Sparrows Point		11. BIRTHPLACE (State or foreign country) New York, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salvatore Cincotta				14. MOTHER'S MAIDEN NAME Marie DeAngelo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-0954		17. INFORMANT Mrs. Sadie Brocato		Address 403 Register Ave. 12	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno carcinoma, primary site undetermined DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 5, 1917 , to Feb 17, 1960 , that I last saw the deceased alive on Feb 17, 1960 , and that death occurred at 330 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Nathan E. Needle M.D. 4215 Park Heights Ave 2/19/60 PHYSICIAN'S NAME (Type) NATHAN E. NEEDLE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/60		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Farace, Inc.				ADDRESS 712-14 E. North Ave.		24a. REC'D BY REGISTRAR FEB 19 60 DATE	
				24b. REGISTRAR'S SIGNATURE William S. Funn			

1605 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>920 Belgian Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Jean</i> Middle <i>C.</i> Last <i>Clark</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>18</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 26, 1893</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i> Hours <i>6</i> Min.	IF UNDER 24 HRS. Months <i>6</i> Days <i>6</i> Hours <i>6</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Orlando Price</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Berry</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		INFORMANT <i>Mrs. Berry Rogers</i> Address <i>Box 153 Record Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>414X</i> <i>Rheumatic cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>?</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebrovascular accident</i> 2-14-60			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb 14</i> , 1960, to <i>Feb 18</i> , 1960, that I last saw the deceased alive on <i>Feb 18</i> , 1960, and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Fredrick J. Vollmer</i>		ADDRESS (Street, city or town, state) <i>6100 York Rd Balto-12</i> DATE SIGNED <i>2-22-60</i>	
PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb 23, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loschn Funeral Home</i>		ADDRESS <i>7401 Belair Rd</i>	
24a. REC'D BY REGISTRAR <i>Feb 24 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1803

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED: John A. Smith

AGE: 45 YEARS

SEX: Male

RACE: White

DATE OF DEATH: Jan 15 1883

PLACE OF DEATH: At home

Cause of Death: Heart Disease

Signature of Physician: Dr. J. B. Smith

Signature of Registrar: Wm. A. Smith

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1606 CERTIFICATE OF DEATH

01588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8019 Ridgely Oak Road</u>				d. STREET ADDRESS <u>8019 Ridgely Oak Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>George H. Cline</u>			4. DATE OF DEATH Month <u>February</u> Day <u>2</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 4, 1880</u>		
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weaver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton Mill</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>								
13. FATHER'S NAME <u>John Cline</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Cox</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Esther M. Wells</u> Address <u>8019 Ridgely Oak Road</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio-sclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1-29</u> , 19 <u>60</u> , to <u>2-2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>60</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <u>Lee K Fargo</u> M.D. <u>8155 LOCH RAVEN BLVD 2-3-60</u>				PHYSICIAN'S NAME (Type) <u>DR LEE K FARGO</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burgee Funeral Home</u> ADDRESS <u>3631 Falls Road</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. DIST. NO.

MARYLAND COUNTY

PRELIMINARY

DECEASED

DATE OF DEATH

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01589

Reg. Dist. No.

1607

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b 10 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 444 Edgewater Apts.			d. STREET ADDRESS 444 Edgewater Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James B. Collins			4. DATE OF DEATH Feb. 7, 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1871		9. AGE (In years last birthday) 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Tenn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME R. H. Collins		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 415-32-6892			17. INFORMANT Laura Collins Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio Sclerotic Heart Dis. [a], stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH 2 hrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Jack C. Collins			DATE SIGNED 2-7-60		
EXAMINER'S NAME (Type) Jack C. Collins			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2/8/60		22c. NAME OF CEMETERY OR CREMATORY Irish Cemetery	
22d. LOCATION (City, town, or county) Claiborne Co., Tenn.		22e. (State) Tenn.		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski ADDRESS 1407 Eastern Ave.			24a. REC'D BY REGISTRAR FEB 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-4. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 5 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01590

1608

1. NAME OF DECEASED (Type or Print) Miss Mary M. Connor		2. DATE OF DEATH 2/20/1960	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Baltimore County</i> FULL NAME OF HOSPITAL OR INSTITUTION Mercy Villa ADDRESS OR LOCATION 6400 Bellona Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS 1524 Lakeside Ave.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2/2/1882
9. AGE (In years last birthday) 78		10. CITIZEN OF WHAT COUNTRY? U.S.	
11. BIRTHPLACE (State or foreign country) Texas, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael F. Connor		14. MOTHER'S MAIDEN NAME Mary Fitzgerald	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 1524 Lakeside Ave.	
17. INFORMANT Miss Isabel deC Connor		ADDRESS 1524 Lakeside Ave.	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc., it means the disease, injury or complication which caused death.) 420.0		CAUSE OF DEATH (A) Coronary Heart Failure DUE TO (B) Arteriosclerosis Heart Disease DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 years 10 years
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus		19a. DATE OF OPERATION February 1960		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes Mellitus
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from November 1956 to February 1960 that (I) (we) last saw the deceased alive on February 20 1960 and that in (my) (our) opinion death occurred at 9:45 A.M. from the causes and on the date stated above.		22. SIGNATURE Edmund Paul Coffey
23a. SIGNATURE Edmund Paul Coffey		23b. ADDRESS 2843 St. Paul St		23c. DATE SIGNED 2/22/60

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/23/60	24c. NAME OF CEMETERY OR CREMATORY St. Joseph's, Texas, Md.	24d. LOCATION (City, town, or county) (State) Texas, Maryland
25a. DATE REC'D BY HEALTH DEPT. FEB 23 1960		25b. NAME OF REGISTRAR H. H. Mease		25c. FUNERAL DIRECTOR H. H. Mease
25d. ADDRESS 805 N. Calvert St. 12				

THIS IS A PERMANENT RECORD.
ALL INFORMATION SHOULD BE CAREFULLY SUPPLIED.
WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

1609

01591

ARLINGTON S. PHILLIPS, 1808 N. MONROE ST., BALTO., MD.

1963 - CERTIFICATE OF DEATH

NAME

DATE

AGE

SEX

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SEX

DATE

DATE OF DEATH

PLACE OF DEATH

SEX

U.S.A.

DATE OF DEATH

PLACE OF DEATH

SEX

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U.S.A.

DATE OF DEATH

1610 CERTIFICATE OF DEATH

01592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 168 Dumbarton Road		d. STREET ADDRESS 1614 Wilkens Ave.	
3. NAME OF DECEASED (Type or print) First KATHERINE Middle CORCORAN Last CORCORAN		4. DATE OF DEATH Month Feb. Day 19 Year 19 60	
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1875
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) County Galway, Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Burke		14. MOTHER'S MAIDEN NAME --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. Bourke Corcoran		Address 1608 Wilkens Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac dilatation 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Chronic myocarditis DUE TO (c) Renovascular disease & hypotension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan 1 , 19 60 , to Feb 18 , 19 60 , that I last saw the deceased alive on Feb 16 , 19 60 , and that death occurred at 12 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Calas		ADDRESS (Street, city or town, state) 477 Fallow Dr	
PHYSICIAN'S NAME (Type) A. E. CAIAS		DATE SIGNED Balto Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-22-60	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) 4300 Old Frederick Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE THOMAS J. KENNY, INC		24a. REC'D BY REGISTRAR FEB 23 '60	
ADDRESS 1600 HOLLINS ST.		24b. REGISTRAR'S SIGNATURE Anthony S. Krasik	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1910 CERTIFICATE OF DEATH

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1 1611 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01593

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 900 Cathedral St	
3. NAME OF DECEASED (Type or print) First ROBERT L. Middle CROSS Last WHITE		4. DATE OF DEATH Month 2 Day 21 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector of Customs		10b. KIND OF BUSINESS OR INDUSTRY Funerals Inc.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Bryant Crosswhite		14. MOTHER'S MAIDEN NAME Kate Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 579-16782	
17. INFORMANT Personal History		Address Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary TBC 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) none		INTERVAL BETWEEN ONSET AND DEATH 22 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 17, 1941 , to Feb 21, 1960 , that I last saw the deceased alive on Feb 19, 1960 , and that death occurred at 11:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton B. Kress M.D.		Eudowood Sanatorium	
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2-24-60	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Ruckelshaus		24a. REC'D BY REGISTRAR DATE FEB 9 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Kress			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1612 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson-				c. LENGTH OF STAY IN 1b 5 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice				d. STREET ADDRESS 4003 Edmondson Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Anna Middle Pamela Last Cummins		4. DATE OF DEATH		Month 2 Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1876		9. AGE (In years lost birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Logue				14. MOTHER'S MAIDEN NAME Harriett Lucas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Gladys Wilson Address 2021 Winford			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting Aneurysm 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Renal Vascular Dis DUE TO (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH 2 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1956 to Feb 28, 1960 , that I last saw the deceased alive on Feb 28, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/28/60							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				PHYSICIAN'S NAME (Type) Charles F. O'Donnell			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-2-1960		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Glenn F. Seitz ADDRESS 5209 York Rd				24a. REC'D BY REGISTRAR MAR 2 1960		24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>1900</u></p>	
<p>5. Place of birth: <u>MASSACHUSETTS</u></p>		<p>6. Date of death: <u>1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1945</u></p>		<p>12. Office of registration: <u>Boston</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 1613 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY in 1b <u>21yrl9dys</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3101.4 d. STREET ADDRESS <u>154 North Curley Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>D'Adamo</u> Last <u>D'Adamo</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 11, 1915</u> 44 yrs.
9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u>19</u> Min. <u>60</u>	11. IF UNDER 24 HRS. Months <u>4</u> Days <u>11</u> Hours <u>19</u> Min. <u>60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank P. D'Adamo</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Rose Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>220-87-5103</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u>SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheal obstruction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Epileptic seizure while eating food</u> (c) <u>food into the trachea</u> DUE TO stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt. apparently sustained seizure while eating evening meal and apparently aspirated</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. apparently sustained seizure while eating evening meal and apparently aspirated food into the trachea</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>20c. TIME OF INJURY Month, Day, Year Hour <u>6:15</u> P. M. <u>2-11</u> 19 <u>60</u></u>		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20c. CITY OR TOWN (County) (State) <u>Catonsville</u> <u>28</u> <u>Maryland</u>		20d. (City or town) (County) (State) <u>Catonsville</u> <u>28</u> <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-12-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BLABROWSKI 2818 E. BALTIMORE ST.</u>		24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>	
ADDRESS <u>BALTIMORE ST.</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. H. H. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1614

1614

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01596

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3101-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1625 Beason Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle P. Last DALEY		4. DATE OF DEATH Month FEBRUARY Day 27 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/84
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grain Inspector		10b. KIND OF BUSINESS OR INDUSTRY B&O Railway	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Daley		14. MOTHER'S MAIDEN NAME Mary Daley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I 217-20-1705	
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) METASTASIS			INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 18 , 19 60 , to Feb. 27 , 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 27 , 19 60 , and that death occurred at 6:25 PM on the causes and on the date stated above.			
22a. SIGNATURE <i>Charles Allen, M.D.</i> M.D.		22b. DATE SIGNED 2/27/60	
22c. PHYSICIAN'S NAME (Type) CHARLES ALLEN, M.D.		22d. ADDRESS VAH, BALTO. MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/2/60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens <i>Funerari</i>		25a. REC'D BY REGISTRAR MAR 3 '60	
ADDRESS 1501 E. Fort Ave. Baltimore 30, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur J. Kuntz</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of Applicant		Address	
Name of Agent		Address	
Name of Firm		Address	
Name of Manufacturer		Address	
Name of Distributor		Address	
Name of Retailer		Address	
Name of Importer		Address	
Name of Exporter		Address	
Name of Shipper		Address	
Name of Receiver		Address	
Name of Consignee		Address	
Name of Consignor		Address	
Name of Agent		Address	
Name of Firm		Address	
Name of Manufacturer		Address	
Name of Distributor		Address	
Name of Retailer		Address	
Name of Importer		Address	
Name of Exporter		Address	
Name of Shipper		Address	
Name of Receiver		Address	
Name of Consignee		Address	
Name of Consignor		Address	

TO HOSPITAL QUALIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1615 CERTIFICATE OF DEATH

Reg. Dist. No. 01597

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home 301 W. Chesapeake Ave.		d. STREET ADDRESS 421 Regester Avenue,	
3. NAME OF DECEASED (Type or print) John H. Davis Sr.		4. DATE OF DEATH Month February Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret'd) Bay Captain		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Davis		14. MOTHER'S MAIDEN NAME Sarah Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT J. Gordon Davis		Address 421 Regester Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Accompanying Cardiac Vascular Disease 443x DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 10 , 19 59 , to Feb 21 , 19 60 , that I last saw the deceased alive on Feb 21 , 19 60 , and that death occurred at 9:38 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post		DATE SIGNED 2/23/60	
PHYSICIAN'S NAME (Type) LAURENCE C. Post		ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN A. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH JAN 15 1917		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. PREVIOUS ILLNESS None	
10. OCCASION OF DEATH Sudden		11. PLACE OF BIRTH Maryland		12. DATE OF BIRTH JAN 15 1872	
13. NAME OF FATHER JOHN A. SMITH		14. NAME OF MOTHER MARY A. SMITH		15. NAME OF SPOUSE None	
16. NAME OF PHYSICIAN DR. J. H. SMITH		17. NAME OF BURIAL PLACE St. John's Church		18. NAME OF MINISTER Rev. J. H. SMITH	
19. NAME OF REGISTRAR J. H. SMITH		20. NAME OF CLERK J. H. SMITH		21. NAME OF WITNESS J. H. SMITH	
22. NAME OF DECEASED'S NEXT OF KIN None		23. NAME OF DECEASED'S NEXT OF KIN None		24. NAME OF DECEASED'S NEXT OF KIN None	
25. NAME OF DECEASED'S NEXT OF KIN None		26. NAME OF DECEASED'S NEXT OF KIN None		27. NAME OF DECEASED'S NEXT OF KIN None	
28. NAME OF DECEASED'S NEXT OF KIN None		29. NAME OF DECEASED'S NEXT OF KIN None		30. NAME OF DECEASED'S NEXT OF KIN None	
31. NAME OF DECEASED'S NEXT OF KIN None		32. NAME OF DECEASED'S NEXT OF KIN None		33. NAME OF DECEASED'S NEXT OF KIN None	
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1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. DISEASE OR INJURY
9. PREVIOUS ILLNESS
10. OCCASION OF DEATH
11. PLACE OF BIRTH
12. DATE OF BIRTH
13. NAME OF FATHER
14. NAME OF MOTHER
15. NAME OF SPOUSE
16. NAME OF PHYSICIAN
17. NAME OF BURIAL PLACE
18. NAME OF MINISTER
19. NAME OF REGISTRAR
20. NAME OF CLERK
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13 & 14—Phone call from Tickners. 2/5/60mb
1616

CERTIFICATE OF DEATH

Reg. Dist. No.

01598

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>55</u> <u>Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>505 Wilton Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>M.</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>- Christopher Marshaus</u>		14. MOTHER'S MAIDEN NAME <u>Unknown / Henrietta Schesser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. H. Leroy Davis - 505 Wilton Rd.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>Recurrent Carcinoma of the lung</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>13 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 1, 1959</u> to <u>Feb. 1, 1960</u> , that I last saw the deceased alive on <u>Feb. 1, 1960</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. J. Venable, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>7215 York Road</u> DATE SIGNED <u>Feb. 3, 1960</u>	
PHYSICIAN'S NAME (Type) <u>S. J. Venable, Jr. M.D.</u>		<u>Baltimore 12, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons - Balto 17</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hians</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1617 CERTIFICATE OF DEATH

01599

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 80 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1203 NOLAN COURT		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MACK Middle J. Last DAVIS		4. DATE OF DEATH Month FEBRUARY Day 12 Year 1960			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-97	9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR: Months 62 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANDREW DAVIS			
14. MOTHER'S MAIDEN NAME PINKIE NICKELSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1			
16. SOCIAL SECURITY NO. 217-09-7724		17. INFORMANT CLIN REC VAN BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARRHYTHMIA, ACUTE, CAUSE UNDETERMINED DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE; AORTIC INSUFFICIENCY DUE TO OLD LUETIC INVOLVEMENT					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-24-59 to 2-12-60 , that (I) (we) lost saw the deceased alive on 2-12-60 19, and that death occurred 2:05 pm from the causes and on the date stated above.			
22a. SIGNATURE George C. McElPatrick, M.D.		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M.D.	
22d. ADDRESS VAH Balto, Md., Ft. Howard Division		22e. ADDRESS VAH Balto, Md., Ft. Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/17/60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d. LOCATION (City, town, or county) BALTIMORE		23e. STATE MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		24a. ADDRESS 1808-10 N. Monroe St., Baltimore 17, Md.		25a. REC'D BY REGISTRAR DATE FEB 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

1961

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DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1618 CERTIFICATE OF DEATH

01600

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 3 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSAMOND Middle N. Last DEAL		4. DATE OF DEATH Month FEB Day 6 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN W. BROWN		14. MOTHER'S MAIDEN NAME CECILIA J. BARRANGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Frank R. Smith Jr. - Cockeysville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-26 19 57 , to 2-5 19 60 , that (I) (we) last saw the deceased alive on 2-5 19 60 , and that death occurred at 4:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 2/6/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS Cockeysville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-9-60	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE FEB 8 '60	
25b. REGISTRAR'S SIGNATURE William S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1618

CERTIFICATE OF DEATH

01601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Philadelphia Rd. Rt 7</u>				d. STREET ADDRESS <u>Philadelphia Rd. Rt 7</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNE SHIRLEY DITZEL</u>				4. DATE OF DEATH Month Day Year <u>Feb 26 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 18-1925</u>		9. AGE (In years last birthday) <u>34</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric Co. Balto. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Hersfeld.</u>				14. MOTHER'S MAIDEN NAME <u>Mildred R. Bryant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-22-8477</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>193.0</u> DUE TO <u>Stroke/tonia Grade III right temporal lobe</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO _____ (c) DUE TO _____				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 2</u> , 19 <u>60</u> to <u>Feb 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 26</u> , 19 <u>60</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. E. Sobel MD</u>				ADDRESS (Street, city or town, state) <u>447 N. Kenwood Ave. Balto. Md.</u>			
PHYSICIAN'S NAME (Type) <u>Bates</u>				DATE SIGNED <u>2/27/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Crem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Sobel MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice				d. STREET ADDRESS 2832 St. Paul Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Agnes C. Donahue				4. DATE OF DEATH Month Day Year 2 22 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/6/1870	
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Baltimore County, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas Donahue				14. MOTHER'S MAIDEN NAME Frances Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT A. Madorah Donahue 2832 St. Paul Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 15 yrs. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 Days 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 23 1960 to Feb 23 1960 that I last saw the deceased alive on Feb 22 1960 and that death occurred at 12:45 M, from the causes and on the date stated above ADDRESS (Street, City or town, state) 2501 Fair Rd Baltimore Md DATE SIGNED 2/23/60 ACTUAL SIGNATURE Charles F. O'Donnell M.D. PHYSICIAN'S NAME (Type) Charles F. O'Donnell- M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 25, 1960		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Weiss 2nd Son - 805 N. Calvert St.				24a. REC'D BY REGISTRAR DATE FEB 23 1960		24b. REGISTRAR'S SIGNATURE W. S. F. F. F.	

1922 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 78

File This No.

<p>1. Name of Deceased John Doe</p>		<p>2. Sex Male</p>	
<p>3. Date of Birth Jan. 1, 1880</p>		<p>4. Date of Death Dec. 31, 1922</p>	
<p>5. Place of Birth Baltimore, Md.</p>		<p>6. Place of Death Baltimore, Md.</p>	
<p>7. Cause of Death Heart Disease</p>		<p>8. Manner of Death Natural</p>	
<p>9. Signature of Physician J. B. Smith, M.D.</p>		<p>10. Signature of Registrar A. C. Jones</p>	
<p>11. Signature of Coroner W. H. Brown</p>		<p>12. Signature of Burial Officer T. E. White</p>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1621 CERTIFICATE OF DEATH

01603

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE DOWNEY				4. DATE OF DEATH Month Day Year February 7 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1898		9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Friight Handler		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel Downey				14. MOTHER'S MAIDEN NAME Louise Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 217-09-6995		17. INFORMANT Address Clinical Records, VAH, Balto. 18, Md. Ft. Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTS, MULTIPLE, BILATERAL 465 x RHEUMATIC HEART DISEASE WITH CONGESTIVE HEART FAILURE AND AORTIC CALCIFIC VALVULITIS WITH STENOSIS CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Leiomyofibroma, stomach - old. Splenic infarct - old.						INTERVAL BETWEEN ONSET AND DEATH RECENT OLD RECENT OLD	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from Feb. 4 19 60 to Feb. 7 19 60 , that W (we) last saw the deceased alive on Feb. 7 19 60 , and that death occurred at 10:05 PM from the causes and on the date stated above.							
22a. SIGNATURE W. J. PIJANOWSKI				22b. DATE SIGNED 2/8/60			
22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D.				22d. ADDRESS VAH, Balto. 18, Md. Fort Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR DATE FEB 15 '60		25b. REGISTRAR'S SIGNATURE W. J. PIJANOWSKI	
ADDRESS 1808 N. Monroe St., Balto Md.							

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CERTIFICATE OF DEATH

Reg. Dist. No.

01604

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 1mth5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Christopher Last Dudley		4. DATE OF DEATH Month February Day 21 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1883
9. AGE (In years lost birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Dudley		14. MOTHER'S MAIDEN NAME Catherine Norton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-14-3400 Unknown	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) Pneumonia (PNEUMONIA)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 17, 1960 , to FEB 21, 1960 , that I lost sows the deceased olive on FEB 21, 1960 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED ACTUAL SIGNATURE Anthony S. Garofano M.D. PHYSICIAN'S NAME (Type) ANTHONY S. GAROFANO Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 24, 1960	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24. REC'D BY REGISTRAR DATE FEB 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No.

01605

1623

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>3101.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>		d. STREET ADDRESS <u>3707 Ferndale Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Virginia</u> Last <u>Dunning</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-52</u>
9. AGE (In years lost birthday) yrs. <u>8</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Dale Dunning</u>		14. MOTHER'S MAIDEN NAME <u>Carol Helen Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute and chronic, bilateral</u> <u>491X</u> DUE TO <u>bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Let W. Rieckert</u> M.D.		ADDRESS (Street, city or town, state) <u>4307 Mainfield Ave E-22-60</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		<u>Baltimore 14, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Liepner & Sons - Balto</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>	
ADDRESS <u>17th</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural near Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Maria		d. STREET ADDRESS Glenarm Rd.	
3. NAME OF DECEASED (Type or print) Sr. M. Renata Durra		4. DATE OF DEATH Month Feb. Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS.	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anton Durra		14. MOTHER'S MAIDEN NAME Anastasia Zach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sr. Mary Clara		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Coronary renal vascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH sudden 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5 , 19 51 , to Feb 3 , 19 60 , that I last saw the deceased alive on Jan 26 , 19 60 , and that death occurred at 11.30M , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		ADDRESS (Street, city or town, state) 7501 York Rd. Towson 4, Md.	
PHYSICIAN'S NAME (Type) CHARLES F. O'DONNELL		DATE SIGNED 2/3/60.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-6-60.	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NE TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles S. Guler</i>		24a. REC'D BY REGISTRAR DATE 8 '60	
ADDRESS 901 S. CONKLING ST. BALTO., 24 MD.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frawe</i>	

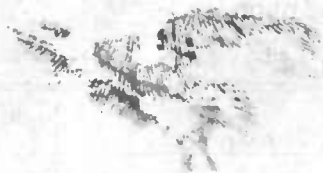
TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

MEDICAL CERTIFICATION

VS A1S (4)
ISM 9/58



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01608

1626 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69x-3	
f. STREET ADDRESS 2375 8th Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUDOLPH Middle N. Last EARL		4. DATE OF DEATH Month FEBRUARY Day 6TH Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/24
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Washer		10b. KIND OF BUSINESS OR INDUSTRY Car Washing	
11. BIRTHPLACE (State or foreign country) Prospect, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Earl		14. MOTHER'S MAIDEN NAME Cornelia Franklin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-18-7679	
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION 161x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) EPIDERMOID CARCINOMA OF LARYNX WITH METASTASIS DUE TO (c) APPROX. 1 YEAR			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1/1 (this hospital) attended the deceased from Feb. 4th 1960 , to Feb. 6th 1960 , that 1/1 (we) last saw the deceased alive on Feb. 6 1960 , and that death occurred at 4:50 PM from the causes and on the date stated above.			
22a. SIGNATURE L. Bruce Smith		22b. DATE SIGNED 2/7/60	
22c. PHYSICIAN'S NAME (Type) L. BRUCE SMITH, M.D.		22d. ADDRESS VAH, BALTIMORE, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/10/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR FEB 11 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus		25c. ADDRESS 1808-10 N. Monroe St. Baltimore 17, Maryland	

1880
CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 3V01.4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 810 Stamford Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rosa Middle B. Last Eaton		4. DATE OF DEATH Month 2 Day 17 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allen Ledwidge		14. MOTHER'S MAIDEN NAME Margaret A. Trout	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Charles E. Compher, 810 Stamford Rd	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V.D. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1969 to July 17, 1969 ; that I last saw the deceased alive on July 16, 1969 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. C. Pender M.D.			
PHYSICIAN'S NAME (Type) J. C. Pender			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope		22d. LOCATION (City, town, or county) (State) Woodsboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.		24a. REC'D BY REGISTRAR FEB 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Thane			

STATEMENT OF DEATH

1937

Mr.

Residence

City

St. Louis, Mo.

Highway and Rural Home

2/17/37

Age

Sex

Color

Nov. 18, 1873

Male

White

Own home

Married

Alfred Ludwig

Mrs. Charles A. Ludwig, St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo.

2/30/37

St. Louis, Mo.

St. Louis, Mo.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1628

CERTIFICATE OF DEATH

Reg. Dist. No.

01610

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 2 Joppa Md.		d. STREET ADDRESS Rt. 2 Joppa Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Fitzhugh L. Edwards		4. DATE OF DEATH Month Day Year February 5, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augusta Fitzhugh		14. MOTHER'S MAIDEN NAME Lucy Tate	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-1756	
INFORMANT Mrs Virginia Simms		Address Rt #2 Joppa Md.	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Dis. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 7 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/21, 1958 , to 2/5, 1960 , that I last saw the deceased alive on 2/5, 1960 , and that death occurred at 5:15 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) FORK, MD. DATE SIGNED	
ACTUAL SIGNATURE Clifford F. Hudson M.D.			
PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-9-1960	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Larsen Funeral Home		24. REGISTRAR'S SIGNATURE Clifford F. Hudson	
ADDRESS 7401 Balaban Road		DATE FEB 10 '60	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0010

STATE OF DEATH

1000

ET

1000

1

1629

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>1 WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>ENGLEHARDT</u> Last <u>ENGLEHARDT</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 26, 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>11</u> Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>METAL SMITH</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL PLATE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>HENRY ENGELHARDT</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA YEAGER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>215-10-2162</u>			
17. INFORMANT <u>HARRY DAYHERTY</u>				Address <u>CEDAR HILL Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO <u>Arterioscl. cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11.3</u> , 19 <u>59</u> , to <u>2.2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2.1</u> , 19 <u>60</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Justina Kudirka</u> M.D. <u>2151 Wilkens Ave</u> <u>2.2.60</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>JUSTINA KUDIRKA</u>				<u>Baltimore, 23. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TACKWOOD MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. County Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab Funeral Home</u> ADDRESS <u>Francis W. Miller 2101 Madison Ave. Balt.</u>				24a. REC'D BY REGISTRAR <u>FEB 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01612

1630

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 4 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle A. Last FAUTH				4. DATE OF DEATH Month FEBRUARY Day 27 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/95	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jobber				10b. KIND OF BUSINESS OR INDUSTRY Candy		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles A. Fauth				14. MOTHER'S MAIDEN NAME Mary Humphrey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I			
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR FAILURE 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE DUE TO (c) DIABETES MELLITUS INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN 6 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) JAUNDICE DUE TO UNDIAGNOSED LIVER DISEASE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 23 , 19 60 , to Feb. 27 , 19 60 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles Allen, M.D. VAH, BALTO. MD. FORT HOWARD DIVISION ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) CHARLES ALLEN, M.D. VAH, BALTO. MD. FORT HOWARD DIVISION							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-2-60		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE George A. Farley Funeral Home				24a. REC'D BY REGISTRAR Frederick & Shady Nook Ave. Balto. Md.		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland

County of Prince George

City of Alexandria

On the _____ day of _____ 19____

At _____

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1631 CERTIFICATE OF DEATH

Reg. Dist. No.

01613

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland c. LENGTH OF STAY IN 1b 3 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Baltimore, Md. b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS 3V01.4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Harrison Middle Walker Last Fincher			4. DATE OF DEATH Month 2 Day 23 Year 19 60		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11/42		9. AGE (In years last birthday) 18 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harry Denkins			14. MOTHER'S MAIDEN NAME Ruth Fincher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		INFORMANT Rosewood Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia with abscess formation 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spastic quadriplegia					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:00aM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Peter W. Rieckert		ADDRESS (Street, city or town, state) 4307 Mainfield Ave Baltimore, Md.		DATE SIGNED 2-23-60	
PHYSICIAN'S NAME (Type) Peter W. Rieckert		Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 26, 60		22c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery	
22d. LOCATION (City, town, or county) Owings Mills, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE FEB 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

1010

CERTIFICATE OF DEATH

1931

Blank form with horizontal lines for text entry.

1632 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS Mills</u>		c. LENGTH OF STAY IN 1b <u>17 YRS.</u> X <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>512 ROSEWOOD STATE TRAINING SCHOOL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. STREET ADDRESS <u>8219 BELAIR ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>LEE</u> Last <u>FOSTER</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>SEPTEMBER</u> Day <u>23</u> Year <u>1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER J. FOSTER</u>		14. MOTHER'S MAIDEN NAME <u>MARY EVELYN MULL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ROSEWOOD RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with empyema of Rt. pleural cavity</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter W. Rieckert</u>		ADDRESS (Street, city or town, state) <u>4307 Maplefield Ave Baltimore 14, MD</u>	
PHYSICIAN'S NAME (Type) <u>Peter W. Rieckert</u>		DATE <u>FEB 23 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 19 60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Kridders Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Myers, Jr., Westminster, Md</u>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE		DATE <u>FEB 23 1960</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

01615

1633

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle I. Last Fox		4. DATE OF DEATH Month 2 Day 6 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881 July 20, 1881
9. AGE (In years last birthday) 78 yrs.		10. UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	11. UNDER 24 HRS. Months 12 Days 12 Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME F.W. Fox		14. MOTHER'S MAIDEN NAME Lucinda Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH years years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 29 , 19 60 to 2/6 , 19 60 , that I last saw the deceased alive on 2/6 , 19 60 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2/6/60	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/60	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Pk.		22d. LOCATION (City, town, or county) (State) Baltimore 7, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave		24a. REC'D BY REGISTRAR FEB 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01010

CENTRAL DEPT.

1033

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Baltimore, Md.

XXXXXX, Md.

XXXXXX, Md.

XXXXXX, Md.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>26 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2317 Old Frederick Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT EDWARD FRANCE</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 6, 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
13. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>THEODORE FRANCE SR.</u>		16. MOTHER'S MAIDEN NAME <u>CHRISTINE IMHOFF</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>213-09-6254</u>	
19. INFORMANT <u>MRS. ELIZABETH FRANCE</u>		Address <u>2317 Old Frederick Rd. Catonsville 28, Md.</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Liver</u> DUE TO (c) <u>2 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 4, 1958</u> , to <u>Feb 6, 1960</u> , that I last saw the deceased alive on <u>Feb 5, 1960</u> , and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Gassaway</u> M.D.		ADDRESS (Street, city or town, state) <u>Elliot City, Md.</u> DATE SIGNED <u>2-6-60</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM F. GASSAWAY</u>		<u>ELLICOTT CITY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/9/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ELLICOTT CITY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>		24. REC'D BY REGISTRAR <u>FEB 9 '60</u> DATE	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Traub</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/58

CERTIFICATE OF DEATH

William F. Thompson
—
Cousin of John

At 2 00 PM on 28 Feb 1914
at 14
about 6 PM
at 10 PM

1635

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>2 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>J CLARENCE FRANCIS</u>				4. DATE OF DEATH Month Day Year <u>FEB 21 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23, 1880</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ALBERT FRANCIS</u>				14. MOTHER'S MAIDEN NAME <u>EMMA V HENRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-24-4766</u>		INFORMANT <u>MYRTLE BUSHMAN</u>		Address <u>Box 25 WATERLOO</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Carcinoma of the Stomach with Metastases.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/31/60</u> , 19 <u>60</u> , to <u>2/21/60</u> , that I last saw the deceased alive on <u>2/20/60</u> 19 <u>60</u> , and that death occurred <u>835A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1308 Frederick Rd Catonsville 28md</u> DATE SIGNED <u>2/22/60</u>							
ACTUAL SIGNATURE <u>W. E. McGrath</u>		M.D. <u>1308 Frederick Rd Catonsville 28md</u>					
PHYSICIAN'S NAME (Type) <u>W. E. McGrath</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/24/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jessie In Funeral Home</u>				ADDRESS <u>7401 Belair Rd. #6</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1636

Item 9 FilmG256 2-23-60 et
 CERTIFICATE OF DEATH

01618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 15, Box 175				c. LENGTH OF STAY IN 1b 8 MOS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle R Last FRYE SR.				4. DATE OF DEATH Month FEB. Day 16 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25-1866	
9. AGE (In years last birthday) 93 1/4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT MEDICAL RECORDS				Address 805 Fuselage Ave. BALTIMORE 20, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS, Generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD FRACTURED HIP INTERVAL BETWEEN ONSET AND DEATH 5 days.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from AUGUST 15, 1959 to FEB 16, 1960 , that I last saw the deceased alive on FEB 15, 1960 , and that death occurred at 9:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. A. Castro, Jr. M.D.				ADDRESS (Street, city or town, state) 805 FUSELAGE AVE 2/17/60			
PHYSICIAN'S NAME (Type) M. A. CASTRO, JR. M.D.				DATE SIGNED BALTIMORE 20, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 2-17-60			
22c. NAME OF CEMETERY OR CREMATORY WINN DALE				22d. LOCATION (City, town, or county) (State) PITTSBURG, PENNSYLVANIA			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly ADDRESS 418 Eastern Blvd.				24a. REC'D BY REGISTRAR FEB 18 '60 DATE			
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

MEDICAL CERTIFICATION

NOTICE

NOTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG257 2-26-60 et

1566 CERTIFICATE OF DEATH

Reg. Dist. No.

01619

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DELLA				c. LENGTH OF STAY IN 1b 25 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 336 DELLA AVE				d. STREET ADDRESS 336 DELLA AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LLOYD THOMAS GAITHER				4. DATE OF DEATH Month 2 Day 21 Year 1960			
5. SEX MALE		6. COLOR OR RACE COLOR		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/1891	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 		11. IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER-RETIRED POULTRY FARM				10b. KIND OF BUSINESS OR INDUSTRY HOWARD G. MD			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LLOYD T. GAITHER				14. MOTHER'S MAIDEN NAME FLORENCE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. ROSIE LEE GAITHER Address DELLA - MD.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-2 , 19 59 , to 2-21 , 19 60 , that I last saw the deceased alive on 2-9 , 19 60 , and that death occurred at 1 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 46 Church Rd DATE SIGNED 2-22-60 ACTUAL SIGNATURE Thomas J. Herbert M.D. Ellicott City, Md PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/24/60			
22c. NAME OF CEMETERY OR CREMATORY White Rock				22d. LOCATION (City, town, or county) (State) Carroll Co. - Md			
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hays ADDRESS 638 N. G. Hwy St Baltimore				24a. REC'D BY REGISTRAR FEB 23 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kloss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01620

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 55 Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				d. STREET ADDRESS 552 Alleghany Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle India Last Gammie				4. DATE OF DEATH Month 2 Day 7 Year 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-1873	
9. AGE (In years lost ^{of day} yrs.) 87		10. AGE (In years lost ^{of day} yrs.) 87		IF UNDER 1 YEAR Months 8 Days 7 Hours 19 Min.		IF UNDER 24 HRS. Months 8 Days 7 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John H. Clary				14. MOTHER'S MAIDEN NAME Margaret Donaldson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Donald Gammie (son) Address 552 Alleghany Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular disease 422.1 DUE TO pneumonitis Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH about 1 yr 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Jan 29 19 60 to Feb 8 19 60 , that (I) (we) last saw the deceased alive on Feb 6 19 60 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE Walter S. Tublett				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Walter S. Tublett				22d. ADDRESS 1501 Pentridge Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 10, 60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) Baltimore, Maryland (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins Sons Co.				ADDRESS 4905 York Rd.		25a. REC'D BY REGISTRAR DATE FEB 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

01020

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
1937
CERTIFICATE OF DEATH

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1638 CERTIFICATE OF DEATH

01621

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Calonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 Smithwood Ave.</u>		d. STREET ADDRESS <u>118 Smithwood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George S. Gardner</u> First Middle Last		4. DATE OF DEATH <u>Feb 11</u> 19 <u>60</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/92</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard T. Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Freeman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>Nettie Carter</u> Address	
17. INFORMANT <u>Nettie Carter</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure (right)</u> <u>434.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor-pulmonale</u> DUE TO (c) <u>Cor-pulmonale</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8, 1960</u> to <u>Feb. 11, 1960</u> that (I) (we) last saw the deceased alive on <u>Feb. 11, 1960</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>R.M. Henning</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>R.M. HENNING</u>		22d. ADDRESS <u>203-Ingleside Ave. Balto. 28</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/15/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>U.S. National</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Natt & Son</u> ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01622
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 7yr8mth23dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell, Maryland			18X-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS ---			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle Edward Last Gass					4. DATE OF DEATH Month February Day 15 Year 1960					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1880		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sailor and farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George W. Gass					14. MOTHER'S MAIDEN NAME Julia Weeden Hardin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal Pneumonia 936.7 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio vascular disease DUE TO Fracture left femur intertrochanteric (c) Fracture left femur intertrochanteric PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On 1-21-60 pt. was pushed down by another patient while walking to the porch sustaining an comminuted intertrochanteric fracture of left femur.										INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 1-21-60 pt. was pushed down by another patient while walking to the porch sustaining an comminuted intertrochanteric fracture of left femur.							
20c. TIME OF INJURY Hour 10:20 a. m. PM Month, Day, Year 1-21-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville 28, Maryland		20g. (County) St. Mary's		20h. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE George M. Kieffer EXAMINER'S NAME (Type) George M. Kieffer, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 2-16-60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/60		22c. NAME OF CEMETERY OR CREMATORY St. Mary's			22d. LOCATION (City, town, or county) (State) St. Mary's			
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Hattaway					ADDRESS Fernandale Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G257 3-1-60 et

CERTIFICATE OF DEATH

01623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 2 yrs. 10 mths	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Amelia Middle Gildea Last Gildea		4. DATE OF DEATH Month February Day 20 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Sauer		14. MOTHER'S MAIDEN NAME Margaret Romosher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William P. Gildea, Jr., 618 Meadow Ridge Rd		Address Towson 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 10, 1958 to February 20, 1960 , that I lost the deceased alive on February 14, 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip D. Flynn		ADDRESS (Street, city or town, state) 11 E. Chase St. DATE SIGNED 2/28/60	
PHYSICIAN'S NAME (Type) Philip D. Flynn, M.D.		Baltimore - 2 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-23-60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson 4		24a. REC'D BY REGISTRAR DATE FEB 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01624

1641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> <u>Towson</u>				c. LENGTH OF STAY IN 1b X <u>Rural</u> <u>Towson</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>				d. STREET ADDRESS <u>Glenarm Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Sister Mary Noreen Gormley</u>				4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>19 60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3, 1891</u>			
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>Jamaica Plain, Mass.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Daniel Gormley</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mc Dermott</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sister M. Peter Fourier</u> Address <u>Notch Cliff, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardio-renal vascular disease</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19 60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Jan. 21</u> , 19 <u>60</u> , to <u>Feb. 18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 16</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7501 York Road Towson 4, Md.</u> DATE SIGNED <u>2/18/60</u> ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SISTERS' CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>N. CHARLES ST. & HOMELAND AVES. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Grier</u> ADDRESS <u>901 S. CONKLING ST. BALTO., 24, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>			

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		April 14, 1928		Jackson, Mississippi	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. DATE OF DEATH	
Attorney		Myocardial infarction		Natural		Baltimore, Maryland		April 4, 1968	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. MEDICAL HISTORY		17. SOCIAL HISTORY		18. FAMILY HISTORY		19. PRESENT ILLNESS		20. POST-MORTEM	
[Text]		[Text]		[Text]		[Text]		[Text]	
21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESS		24. SIGNATURE OF DECEASED		25. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness.

2. The cause of death should be stated in as much detail as possible, and should be based on the findings of the physician or other qualified person.

3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined.

4. The place of death should be stated as the residence of the deceased, a hospital, or some other place.

5. The date of death should be stated in full, including the day, month, and year.

6. The signature of the physician or other qualified person should be written in ink.

7. The signature of the registrar should be written in ink.

8. The signature of the witness should be written in ink.

9. The signature of the deceased should be written in ink.

10. The signature of the next of kin should be written in ink.

11. The medical history should be written in ink.

12. The social history should be written in ink.

13. The family history should be written in ink.

14. The present illness should be written in ink.

15. The post-mortem should be written in ink.

16. The signature of the physician or other qualified person should be written in ink.

17. The signature of the registrar should be written in ink.

18. The signature of the witness should be written in ink.

19. The signature of the deceased should be written in ink.

20. The signature of the next of kin should be written in ink.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1642

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01625

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Washington Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George Francis Griffin				4. DATE OF DEATH Feb. 14 19 60			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1897		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George F. Griffin			
14. MOTHER'S MAIDEN NAME Mary Catherine Nihill				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Helen Dewees Griffin Address Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute CORONARY Occlusion - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mild Hypertension - DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden 1 YR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-24-59 to 2-14-60 , that (I) (we) last saw the deceased alive on 1-23-60 , and that death occurred at 11 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Anthony F. Carozza				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Anthony F. CAROZZA	
				22d. ADDRESS 5217 YORK Rd BALto. 12 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. ADDRESS 4095 York Rd.				25a. REC'D BY REGISTRAR DATE FEB 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1962

11823

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

1643
Baltimore County
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Windsor Mill Rd Ext MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 ALTO COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9 Month X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Windsor Mill Rd Ext	
3. NAME OF DECEASED (Type or print) EMMMA PAULINE GUIBERIATIS		4. DATE OF DEATH 27 27 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 23 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY 13 ALTO MD	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHRISTIAN GAKENHEIMER		14. MOTHER'S MAIDEN NAME CHARLOTTA HECKEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS SIENNIE ECKER WINDSOR MILL RD EXT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - BREAST c 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTASIS TO LUNG (c) GENERALIZED CARCINOMATOSIS		INTERVAL BETWEEN ONSET AND DEATH 4 years / 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC 16, 1959, to FEB 27, 1960, that I last saw the deceased alive on FEB 27, 1960, and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler		DATE SIGNED 2/27/60	
PHYSICIAN'S NAME (Type) THOMAS E. WHEELER		ADDRESS (Street, city or town, state) Randallstown - Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) JOURNAL	22b. DATE THEREOF MAR 2	22c. NAME OF CEMETERY OR CREMATORY LOUDON PK CEMETERY	22d. LOCATION (City, town, or county) (State) FREDERICK AVE
23. FUNERAL DIRECTOR'S SIGNATURE GEDLEIMBACH 5227 LYNDA HURST ST		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH March 24, 1933		11. PLACE OF BIRTH Jackson, Mississippi		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
19. SIGNATURE OF CORONER JAMES EARL RAY		20. SIGNATURE OF JURY JAMES EARL RAY		21. SIGNATURE OF JUDGE JAMES EARL RAY	
22. SIGNATURE OF CLERK JAMES EARL RAY		23. SIGNATURE OF REGISTRAR JAMES EARL RAY		24. SIGNATURE OF ARCHIVIST JAMES EARL RAY	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF MEMPHIS, TENNESSEE, FOR THE PURPOSE OF RECORDING AND INDEXING.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1644 CERTIFICATE OF DEATH

Reg. Dist. No.

01627

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 16 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Phillip Middle S. Last Harbaugh				4. DATE OF DEATH Month February Day 13 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 Jan. 8,		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Charles Harbaugh			
14. MOTHER'S MAIDEN NAME Fannie Brown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. Unknown				INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Age. C. v. Disease (c) Arteriosclerosis general, severe							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5, 1960 to February 13, 1960 , that I last saw the deceased alive on February 13, 1960 , and that death occurred at 3 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachler		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 2/13/60					
PHYSICIAN'S NAME (Type) STELLA WACHSLER		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF Feb. 15, 1960		22c. NAME OF CEMETERY OR CREMATORY FAIRFIELD UNION CEMETARY FAIRFIELD		22d. LOCATION (City, town, or county) (State) PA.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson (P.G.W.) FAIRFIELD, PA.				24a. REC'D BY REGISTRAR Feb 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Manner of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1643 CERTIFICATE OF DEATH

01628

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle (NMI) Last HARRIS				4. DATE OF DEATH Month FEBRUARY Day 14 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/88	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oilier-Fireman		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marines		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harris				14. MOTHER'S MAIDEN NAME Sadie Pentz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I 222-03-8844		17. INFORMANT BENJAMIN F. HARRIS 124 S. HAVEN ST. Clin. Rec. VAH, Balto. Md. Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X XX CARCINOMA OF BLADDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XX DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 2 MONTHS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from Feb. 12 19 60 , to Feb. 14 19 60 , that XX (we) last saw the deceased alive on Feb. 14 19 60 , and that death occurred at 1:38 A.M. on the causes and on the date stated above.							
22a. SIGNATURE <i>John E. Eisenlohr</i>		22b. DATE SIGNED 2/14/60		22c. PHYSICIAN'S NAME (Type) JOHN E. EISENLOHR, M.D.			
22d. ADDRESS VAH, BALTIMORE, MD. FORT HOWARD DIVISION		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/17/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons, Inc.				24a. ADDRESS North Ave. & Broadway		24b. DATE FEB 16 '60	
25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <i>Arthur L. K...</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01629

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (Include corporate limits, write RURAL and give nearest town) <u>Balto, 34</u>	c. LENGTH OF STAY IN 1b <u>4 yr</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 34</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2618 Matthews Drive</u>		d. STREET ADDRESS <u>2618 Matthews Drive</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ALLEN</u> First <u>WATSON</u> Middle <u>HEATH</u> Last		4. DATE OF DEATH <u>4-14</u> Month Day Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 20 1907</u>
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Lt Colonel.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USA</u>	11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Earl Heath</u>	
14. MOTHER'S MAIDEN NAME <u>Isabel Stacey</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> Full time	
16. SOCIAL SECURITY NO. <u>Full time</u>		17. INFORMANT <u>Wife</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330X</u> DUE TO <u>Subarachnoid hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>Repeated Thrombotic Emboli</u> (a), stating the underlying cause last. (c) <u>massive thrombus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1954</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasir Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK T KASIR JR.</u>		DATE SIGNED <u>2/14/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>2-17-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1948

44

101

John Henry Jones
John Henry Jones

DATE OF DEATH
TIME OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

1. I certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.
2. I certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.
3. I certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.
4. I certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.
5. I certify that the above is a true and correct statement of the facts as they came to my knowledge and belief.

JOHN HENRY JONES

JOHN HENRY JONES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1647 CERTIFICATE OF DEATH

Reg. Dist. No.

01630

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b - 14	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7801 Ardmore Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last HEINBUCH		4. DATE OF DEATH Month February Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 5 Days 2 Hours 4 Min.	11. IF UNDER 24 HRS. Months 5 Days 2 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adam Miller		14. MOTHER'S MAIDEN NAME Elizabeth Reese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-12-7892	
17. INFORMANT Mr. N. Hilton Heinbuch		Address 295 Cold Spring Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Suckemia 204.0 DUE TO Bronary infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1945 , 19____, to 2/7/60 , that I last saw the deceased alive on 2/5/60 , 19____, and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4331 Harford Rd. DATE SIGNED ACTUAL SIGNATURE Walter E. Hargwin M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 11, 1960	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC.		24a. REC'D BY REGISTRAR BALTO., Md. 24b. REGISTRAR'S SIGNATURE DATE FEB 10 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1648

Item 23b, Film 6250-11/60-1WK

01631

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 56 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (1)		3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 605 Brune Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OLIVER				4. DATE OF DEATH Month February Day 9 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 22, 1929	
9. AGE (In years lost birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Gastonia, N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Oliver Henderson, Sr.				14. MOTHER'S MAIDEN NAME Ada Neely			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Korean				16. SOCIAL SECURITY NO. 211-26-0876		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OSTEOGENIC SARCOMA, RIGHT ILEUM WITH METASTASES 196.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation Curettage and Drainage, Right Ileum 12/18/60							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from Dec. 15 19 60 to Feb. 9 19 60 that W (we) last saw the deceased alive on Feb. 9 19 60 , and that death occurred at 10:32PM on the causes and on the date stated above.							
22a. SIGNATURE W. J. Pijanowski				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/10/60	
22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D.				22d. ADDRESS VAH, BALTO. 18 MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 15, 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy Wilson Funeral Home, 5501 Balto. Md.				25a. REC'D BY REGISTRAR FEB 24 '60		25b. REGISTRAR'S SIGNATURE Charles S. Evans	

01-31

CERTIFICATE OF DEATH

1968

Deceased

2

Birthdate

11

Deceased

10 days

10 days

1000 Avenue Street

1000 Avenue Street

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1649

CERTIFICATE OF DEATH

01632

Reg. Dist. No.

1. PLACE OF DEATH Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)			
a. COUNTY Baltimore MARYLAND				a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galloway, Maryland			
c. LENGTH OF STAY IN 1b 15 years				18 X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Preston Middle Ignatius Last Hewitt				4. DATE OF DEATH Month 2 Day 3 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/32	
9. AGE (In years lost birthday) 27 yrs.		IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min.		IF UNDER 24 HRS. Months 27 Days 27 Hours 27 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Irving Hewitt				14. MOTHER'S MAIDEN NAME Edith Combs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Rosewood Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grand mal seizure in 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) status epilepticus DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:30M , from the causes and on the date stated above.							
ACTUAL SIGNATURE P. W. Rieckert				ADDRESS (Street, city or town, state) Baltimore 14 Md			
PHYSICIAN'S NAME (Type) P. W. Rieckert				DATE SIGNED 2/3/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2/6/60		Holy Tree		Owings Mills Md	
23. FUNERAL DIRECTOR'S SIGNATURE P. W. Rieckert				24. REC'D BY REGISTRAR FEB 8 '60			
ADDRESS				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon permits. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1650

CERTIFICATE OF DEATH

01633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville				c. LENGTH OF STAY IN 1b about 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8611 Chestnut Oak Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Louise Hild				4. DATE OF DEATH Month Day Year Feb. 14 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1903		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Valentine Staab				14. MOTHER'S MAIDEN NAME Mary Fatcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-28-3162		17. INFORMANT Address Mrs. Frances Cicero 8611 Chestnut Oak Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Angina pectoris DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1/60 , 19 60 , to 2/14 , 19 60 , that I last saw the deceased alive on 2/14 , 19 60 , and that death occurred at 5A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8523 Lock Raven Rd. DATE SIGNED 2/15/60							
ACTUAL SIGNATURE Edwin Grau M.D.				PHYSICIAN'S NAME (Type) Dr. E. Gordon Grau			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Vernon Lemmon ADDRESS 4611 Park Heights Ave.				24a. REC'D BY REGISTRAR FEB 16 1960		24b. REGISTRAR'S SIGNATURE Wm. H. Hume	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of birth		Place of birth		Usual residence		Cause of death		Date of death		Place of death		Time of death		Signature of physician		Signature of registrar	
John Doe		Male		45		Jan 1, 1900		Maryland		Baltimore		Heart disease		Jan 15, 1945		Home		10:00 AM		J. Smith		A. Jones	
Name of informant		Sex		Age		Date of birth		Place of birth		Usual residence		Cause of death		Date of death		Place of death		Time of death		Signature of physician		Signature of registrar	
Jane Doe		Female		40		Jan 1, 1905		Maryland		Baltimore		Heart disease		Jan 15, 1945		Home		10:00 AM		J. Smith		A. Jones	
Name of informant		Sex		Age		Date of birth		Place of birth		Usual residence		Cause of death		Date of death		Place of death		Time of death		Signature of physician		Signature of registrar	
John Doe		Male		45		Jan 1, 1900		Maryland		Baltimore		Heart disease		Jan 15, 1945		Home		10:00 AM		J. Smith		A. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01634

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 1651 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oaklee Village 29</u>		c. LENGTH OF STAY IN 1b <u>29</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>161 Colchester Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>E L L A</u> , <u>Virginia</u> <u>Hoffman</u> First Middle Last		4. DATE OF DEATH <u>Feb.</u> <u>8.</u> <u>1960</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Duties</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Otto L. Bauman</u>		14. MOTHER'S MAIDEN NAME <u>Frances Mewshaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Walter W. Hoffman. 1229 Circle Drive 27</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac congestion</u> <u>443x</u> DUE TO <u>Hypertensive cardio vascular heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		DATE SIGNED <u>Feb. 8, 1960</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		24. REGISTRAR'S SIGNATURE <u>Feb 12 '60</u>	
ADDRESS <u>Fun'1 Home 4107 Wilkens Ave.</u>		DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01635

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1652

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (In this place) <u>3 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u>		<u>34014</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>360 GERDMAN AVENUE 13</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>OSCAR</u>		(Middle) <u>JOHN</u>		(Last) <u>HOOK</u>		(Month) (Day) (Year) <u>2-28-1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9-8-XXXX-86</u>		9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REFINERY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND, Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OSCAR J HOOK, SR.</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE A WELSH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X IMMEDIATE CAUSE (A) <u>FAR ADVANCED PULMONARY TUBERCULOSIS</u>						<u>1 WEEK</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-26-1960</u> , to <u>2-28-1960</u> , that I last saw the deceased alive on <u>2-28-1960</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland				DATE SIGNED <u>2-28-60</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/2/60</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Schunicher Funeral Home</u> ADDRESS <u>2601 E. Madison St.</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6256 2-16-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01636

1653

1. PLACE OF DEATH a. COUNTY <u>Howard Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Howard</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>601 Maiden Choice Lane Daughters of the Eucharist</u>				d. STREET ADDRESS <u>Ligon Rd. R. F. D. 5</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E. HOPWOOD</u> Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 25, 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Kraft</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Schwertz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT Address <u>Mr. Charles A. Hopwood, Jr. Ligon Rd. R.F.D. 5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>ARTERIO SCLEROSIS</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH 18 YRS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/8, 1958</u> to <u>2/7, 1960</u> that I last saw the deceased alive on <u>2/6, 1960</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul R Ziegler</u>		ADDRESS (Street, city or town, state) <u>3723 EDMONDSON AVE</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>PAUL R. ZIEGLER</u>		<u>BALTO. 29, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balt. 17 Md</u>				24a. REC'D BY REGISTRAR <u>FEB 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1552

Reg. Dist. No.

01637

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb 20 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 711 Meadow Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
3. NAME OF DECEASED (Type or print) Alfred Irvin Hubert Sr.		4. DATE OF DEATH Month Feb. Day 7, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1926
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Consolidated Eng. Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred W. Hubert		14. MOTHER'S MAIDEN NAME Helen Wloczewski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-14-8057	
17. INFORMANT Mrs. Eula Hubert		Address 711 Meadow Ave. 22, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Carditis & Mitral Stenosis + Insuff. a. regency = DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 410X (c)			INTERVAL BETWEEN ONSET AND DEATH 4
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis, M.D.		DATE SIGNED 2/10/60	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-10-1960	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Eastern Blvd, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Avenue 22, Md.	
24a. REC'D BY REGISTRAR DATE FEB 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. File pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		CITY		COUNTY		STATE		ZIP CODE		CITY	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SOCIETY		MILITARY SERVICE	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		AUTOPSY		HISTOLOGY		LABORATORY	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF JURY		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF JUDGE		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF CLERK		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF ATTORNEY		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF CHURCH		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF FUNERAL HOME		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF BURIAL		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF INTERMENT		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF RECORDS		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF VITALS		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF DEATH		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF BIRTH		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF MARRIAGE		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF DIVORCE		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF WEDDING		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF BAPTISM		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF CONFIRMATION		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF FIRST COMMUNION		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF LAST RITES		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF BURIAL		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF INTERMENT		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF RECORDS		DATE		TIME		PLACE		CITY		STATE	
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SIGNATURE OF CONFIRMATION		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF FIRST COMMUNION		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF LAST RITES		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF BURIAL		DATE		TIME		PLACE		CITY		STATE	
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SIGNATURE OF VITALS		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF DEATH		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF BIRTH		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF MARRIAGE		DATE		TIME		PLACE		CITY		STATE	
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SIGNATURE OF WEDDING		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF BAPTISM		DATE		TIME		PLACE		CITY		STATE	
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SIGNATURE OF BURIAL		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF INTERMENT		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF RECORDS		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF VITALS		DATE		TIME		PLACE		CITY		STATE	
SIGNATURE OF DEATH											

1654 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28				c. LENGTH OF STAY IN 1b 3701.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home-Rolling Rd.				d. STREET ADDRESS 4644 Rokeby Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EUTHA Middle A. Last HUDSON				4. DATE OF DEATH Month Feb. Day 20. Year 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 7, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min. 78		IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Md.							
13. FATHER'S NAME James H. Wood				14. MOTHER'S MAIDEN NAME Elizabeth Catherine Downs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Miss Ida Wood - 4644 Rokeby Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency DUE TO 216x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pseudomucinous cystadenoma left ovary (c) intestinal obstruction, peritonitis						INTERVAL BETWEEN ONSET AND DEATH 6 wks - 4 yrs 7 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 22, 1955 to Feb 20, 1960 , that I last saw the deceased alive on Feb 20, 1960 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George A. Knipp				ADDRESS (Street, city or town, state) 4416 Edmondson Ave Balto., 29 Md			
DATE SIGNED Feb 21 1960							
PHYSICIAN'S NAME (Type) George A. Knipp, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balto				ADDRESS 17 Md		24a. REC'D BY REGISTRAR DATE FEB 24 '60	
24b. REGISTRAR'S SIGNATURE Curtis E. Frank							

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1655

01639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 333 George Ave.		d. STREET ADDRESS 333 George Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN FRANK HUPPMAN SR.		4. DATE OF DEATH Month February Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1890
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Huppmann		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-03-9402	
17. INFORMANT John F. Huppmann Jr.		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Disease 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asthma (chronic) (c) Asthma (chronic)			INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/60	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski		24a. REC'D BY REGISTRAR DATE FEB 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01640

1656

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The House in the Pines 16 Fusting Avenue</u>				d. STREET ADDRESS <u>104 East Madison Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Mary</u> Middle <u>Irving</u> Last <u>Irving</u>		4. DATE OF DEATH		Month <u>February</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1885</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hutzler's Bro.</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-10-6587</u>		17. INFORMANT <u>Mrs. Louis Roche, 301 Gittings Avenue</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Chronic Hypertensive Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>5 yr.</u> <u>5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-17-</u> , 19 <u>59</u> , to <u>2-22-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-21-</u> , 19 <u>60</u> , and that death occurred at <u>6:30 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wibmer K. Gallager</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave Baltimore 28 Md.</u>			
DATE SIGNED <u>2-23-60</u>							
PHYSICIAN'S NAME (Type) <u>Wibmer K. Gallager</u>		Baltimore 28 Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> ADDRESS				24a. REC'D BY REGISTRAR <u>FEB 25 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01641

1657 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8,9 Film G256 2-23-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 164 Winters Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Douglas First Middle Last Jensen		4. DATE OF DEATH Feb. 13, 1960 19	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1910 ?
9. AGE (In years last birthday) 49 1/2 yrs?		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A Jensen		14. MOTHER'S MAIDEN NAME Alice R Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S.M. Kieffer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S.M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-17-60	
22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Rence A. Hewley		ADDRESS 578 W. Biddle St.	
24a. REC'D BY REGISTRAR DATE FEB 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

1651

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Physical Examination		Mental Examination	
Autopsy		Toxicology		Microbiology	
Radiology		Histology		Immunology	
Genetics		Pharmacology		Pathology	
Other		Other		Other	

MADE IN U.S.A. 10-30-AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

1. **CERTIFICATE OF DEATH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01642

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 90 Days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (6) d. STREET ADDRESS 1312 Evering Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) LAWRENCE E. JOHNSON First Middle Last				4. DATE OF DEATH February 4 1960 Month Day Year											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1894		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Johnson						14. MOTHER'S MAIDEN NAME Elizabeth Schreiber									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 217-09-7999				17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS XXXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS XXXXXX (c) PNEUMONITIS												INTERVAL BETWEEN ONSET AND DEATH SUDDEN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ABOVE KNEE AMPUTATION, LEFT -Operation 1/21/60														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from November 6, 1959, to February 4, 1960, that (X) (we) last saw the deceased alive on Feb. 4, 1960, and that death occurred at 8:45 AM, from the causes and on the date stated above.															
22a. SIGNATURE <i>W. J. Pijanowski</i> 22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D.						22b. DATE SIGNED 2/4/60 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-6-60		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park				23d. LOCATION (City, town, or county) Baltimore Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Road, Balto. 14 Md.						25a. REC'D BY REGISTRAR FEB 8 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

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1. *X*

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1659

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01643

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 30 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 103 North Payson Street (23) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MOSES Middle --- Last JOHNSON				4. DATE OF DEATH Month February Day 18 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1895	
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 19 Min.		11. IF UNDER 24 HRS. Months 6 Days 18 Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver				10b. KIND OF BUSINESS OR INDUSTRY Trucking		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Joshua Johnson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I 218-10-4999		17. INFORMANT Address Division Clin. Records, VAH, Balto. 18, Maryland, Ft. Howard/			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA WITH PULMONARY EDEMA DUE TO HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ARTERIOSCLEROSIS, MARKED, GENERALIZED X XXXX SPLENIC INFARCTS, MULTIPLE (c) BENIGN PROSTATIC HYPERTROPHY,						INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL EDEMA, RECENT.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 19 19 60 to February 18 19 60 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/18/ 1960 , and that death occurred on 2/19/60 from the causes and on the date stated above.							
22a. SIGNATURE <i>W. J. Pijanowski</i>				22b. DATE SIGNED 2/19/60		22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/24/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR FEB 24 1960		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Piana</i>	
25c. ADDRESS 1808 N. Monroe St. Balto 17, Md.				25d. DATE FEB 24 1960		25e. SIGNATURE <i>Arthur S. Piana</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

2011.11.17

125

Reg. Dist. No.

MEDICAL CERTIFICATION

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARITAL STATUS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS MISCELLANEOUS

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1661
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1661
CERTIFICATE OF DEATH

01645

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		MARYLAND c. LENGTH OF STAY IN 1b 164 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Route #3, Box 101			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle --- Last JONES		4. DATE OF DEATH Month February Day 29 Year 1960					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1892		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Easton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Jones		14. MOTHER'S MAIDEN NAME Harriet Corness					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT LUNG 162.1 XXXX METASTATIC CARCINOMA, LIVER AND ADRENAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) BRONCHOPNEUMONIA, LEFT LUNG XXXX ARTERIOSCLEROSIS, MARKED, GENERALIZED (c) NEPHROSCLEROSIS, ARTERIOSCLEROTIC						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from Sept. 18, 1959 to Feb. 29, 1960 , that W (we) last saw the deceased alive on 6:59 AM 2/29/60 , and that death occurred at 6:59 PM from the causes and on the date stated above.							
22a. SIGNATURE W. J. Pijanowski				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/29/60	
22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D.				22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-60		23c. NAME OF CEMETERY OR CREMATORY Unionville Cemetery		23d. LOCATION (City, town, or county) (State) Route One, Easton, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell Funeral Home, Easton, Md.				25a. REC'D BY REGISTRAR MAR 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

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continued

00-5901-11-7-2-10-05

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1500

STUDY OF THE EFFECTS OF

U.S. DEPARTMENT OF JUSTICE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1662

1662

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01646

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall				c. LENGTH OF STAY IN lb life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wiseburg Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Emory Last Jones				4. DATE OF DEATH Month 2-28-60 Day 19 Year 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH X 7-24-1879	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY paper mill		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Randolph R. Jones			
14. MOTHER'S MAIDEN NAME Mary Virginia Bull				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214-20-9428				17. INFORMANT Minnie V. Jones, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) after hours (c) after hours				INTERVAL BETWEEN ONSET AND DEATH after hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 27 , 19 59 , to Feb 28 , 19 60 , that I last saw the deceased alive on Feb 27 , 19 60 , and that death occurred at 11 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) White Hall, Maryland DATE SIGNED Milner Bortner							
ACTUAL SIGNATURE Milner Bortner M.D.				PHYSICIAN'S NAME (Type) Milner Bortner, M.D. White Hall, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-2-60			
22c. NAME OF CEMETERY OR CREMATORY Wiseburg Methodist				22d. LOCATION (City, town, or county) (State) White Hall, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				24a. REC'D BY REGISTRAR MAR 7 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kram							

422

Abstract

60-sec 60-sec

EV91-HS-1

1975

(continued)

1993-1994

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Journal of Applied Gerontology

• 2004 •

CERTIFICATE OF DEATH

Reg. Dist. No.

01647

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8058 Philadelphia Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle J. Last Joska		4. DATE OF DEATH Month February Day 20 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1898
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY own business	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank J. Joska		14. MOTHER'S MAIDEN NAME Anna Liska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Carrie Sellier Joska, wife, above	
17. INFORMANT Carrie Sellier Joska, wife, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10/27/59? 10/27/59?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/27, 1959 , to 2/20, 1960 , that I last saw the deceased alive on 2/20, 1960 , and that death occurred at 5 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis F. Klimes M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 2/22/60	
PHYSICIAN'S NAME (Type) LOUIS F. KLIMES M.D.		2623 E. Monument St - 5	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/24/60	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS Funeral Home 3331 Brehms Lane	
24a. REC'D BY REGISTRAR DATE FEB 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 Item 2 Film 259 3-28-60 et 1664 1664 01648 Reg. Dist. No. 1 514 1 TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>11yr3mth19dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Joyce</u>				4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1886</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug. 10, 1959</u> , to <u>Feb. 10, 1960</u> , that I last saw the deceased alive on <u>Feb. 10, 1960</u> , and that death occurred at <u>3:10p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>2-11-60</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>2/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>4300 rd Frederick</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Bates</u>				ADDRESS <u>1318 Light</u>		24a. REC'D BY REGISTRAR <u>FEB 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

1665 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4 ✓	
c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (26)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4001 Fairhaven Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle B. Last JUMP		4. DATE OF DEATH Month February Day 4 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1912	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) St. Michaels, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Giles H. Jump		14. MOTHER'S MAIDEN NAME Ethel Mary Marshall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-01-9346		INFORMANT Address Clinical Records VAH, Balto. 18, Md. FT. HOWARD DIV.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, 420.1 DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) XXX PULMONARY CONGESTION AND EDEMA, MARKED (c) ARTERIOSCLEROSIS, MODERATE, OLD					INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from January 31, 1960 to February 4, 1960 and that death occurred on the date stated above. 1:10 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>W. J. Pijanowski</i>		ADDRESS (Street, city or town, state) M.D. VAH, BALTO 18, MD. FT. HOWARD DIV. DATE SIGNED 2/4/60			
PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-60		22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery	
22d. LOCATION (City, town, or county) Saint Michaels, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hambleton Harrison</i> Hambleton Harrison		ADDRESS Saint Michaels, Maryland		24a. REC'D BY REGISTRAR SEP 8 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Piana</i>	

TO HOSPITAL. ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Introduction

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1001 Palgrave Avenue

February

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207-01-2225 Clinical Records VAN Buren, J. & W. HOWARD DEW.

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Journal of Management Education 30(6)

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Figure 1

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Forleg Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> Middle Last <u>Kabik</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>17</u> - Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/1898</u> 62 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		9b. AGE (In years last birthday) <u>62</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>London, Eng</u>	
11. BIRTHPLACE (State or foreign country) <u>London, Eng</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert Kabik</u>		14. MOTHER'S MAIDEN NAME <u>Bessie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Anna Kabik - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Metastases due to Hypertension</u> (b) <u>Hypertension left = Pulmonary Metastases</u> (c) <u>Dehydration & emaciation</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 10, 1959</u> to <u>Feb 17, 1960</u> that I last saw the deceased alive on <u>Feb 17, 1960</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. William Pimack</u> M.D.		DATE SIGNED <u>Feb 17, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Dr. H. William Pimack</u>		ADDRESS <u>Baltimore 17, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2106 Eutan Place</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]

(1)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Back River		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Back River			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 401 Island Point Road				d. STREET ADDRESS 401 Island Point Road			
3. NAME OF DECEASED (Type or print) First Matthew Middle Charles Last Kalb				4. DATE OF DEATH Month February Day 14 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1892		9. AGE (In years last birthday) 67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Baltimore	12. CITIZEN OF WHAT COUNTRY? 		
13. FATHER'S NAME John Kalb			14. MOTHER'S MAIDEN NAME Mary				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Delores Harris 233 N. Morlyn Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 2 hrs 5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins M.D.				DATE SIGNED 2-15-60			
EXAMINER'S NAME (Type) Jack C. Collins				DEPUTY MEDICAL EXAMINER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 18, 1960		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart			
22d. LOCATION (City, town, or county) Baltimore, Maryland		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 1901 Eastern Avenue			24a. REC'D BY REGISTRAR DATE FEB 17 '60		24b. REGISTRAR'S SIGNATURE Curtis S. Frank		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1668 CERTIFICATE OF DEATH

Reg. Dist. No.

01652

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5yr6mth18dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle John Last Kalmbacher				4. DATE OF DEATH Month February Day 22 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 11, 1883	
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Decorative Painter				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Kalmbacher				14. MOTHER'S MAIDEN NAME Barbara Schantz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. 213-30-8713			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA - BILATERAL 491X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 19 , 19 60 to Feb 22 , 19 60 , that I last saw the deceased alive on Feb. 22 , 19 60 , and that death occurred at 6:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-22-60							
ACTUAL SIGNATURE Anthony S. Garofano M.D.				PHYSICIAN'S NAME (Type) ANTHONY S. GAROFANO Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 25 - 1960			
22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery				22d. LOCATION (City, town, or county) (State) Chesapeake Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John F. Garrison				24a. REC'D BY REGISTRAR DATE MAR 1 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. House							

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1888 CINCINNATI & OHIO

MADE IN U.S.A.

MADE IN U.S.A.

MADE IN U.S.A.

1669

CERTIFICATE OF DEATH

01653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS Mills		c. LENGTH OF STAY IN 1b 8 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TRAINING SCHOOL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PEGGY Middle VIRGINIA Last KAMPE		4. DATE OF DEATH Month FEBRUARY Day 15 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9, 1930 yrs. 29
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months + Days + Hours + Min. +	11. IF UNDER 24 HRS. Months + Days + Hours + Min. +
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DOUGLAS FOSTER KAMPE		14. MOTHER'S MAIDEN NAME VIRGINIA OLIVIA DEHRING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma Diabeticum 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Petz W. Rieckert		ADDRESS (Street, city or town, state) 4307 Mainfield Ave Baltimore 14 Md	
PHYSICIAN'S NAME (Type) Petz W. Rieckert		DATE SIGNED 2-16-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 2-17-60	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR DATE FEB 19 '60	
ADDRESS 5305 Harford Rd		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

Page 4 death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

683

Deceased Person's Name

Residence

Age

Date of Death

Place of Death

Signature of Registrar

Signature of Deceased

Signature of Witness

1670 CERTIFICATE OF DEATH

01654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE-19 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE AS b. COUNTY IN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) IN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7000 N. POINT RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle KAPLAN Last KAPLAN		4. DATE OF DEATH Month FEB Day 6 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 5. 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Schwartz		14. MOTHER'S MAIDEN NAME Edith (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT EDITH K. SMULSON		Address AS IN #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility and arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 23 , 19 60 , to FEB 6 , 19 60 , that I last saw the deceased alive on FEB 5 , 19 60 , and that death occurred at 6 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis N. Tellin		ADDRESS (Street, city or town, state) 6908 N. POINT RD. DATE SIGNED 2/6/60	
PHYSICIAN'S NAME (Type) LOUIS N. TELLIN M.D.		Baltimore-19-2nd	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2-8-60	Brook Abraham Hagerstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Kurish		ADDRESS 2100 Eutaw Place	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE FEB 9 '60		Arthur S. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b 54 Essex (21)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1806 Elk Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN C. KEICHENMEISTER		4. DATE OF DEATH Month February Day 14 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1872
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-8359	
17. INFORMANT Harry Keichenmeister		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } Arteriosclerotic Cardiovascular disease DUE TO (c) 2 yrs			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 19 60 , to Feb 14 , 19 60 , that I last saw the deceased alive on Feb 14 , 19 60 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE MB Baumgardner		ADDRESS (Street, city or town, state) Balto 6 Md	
PHYSICIAN'S NAME (Type) James C. Bruzdinski		DATE SIGNED 2/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/17/60	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE James C. Bruzdinski		24a. REC'D BY REGISTRAR FEB 17 '60	
ADDRESS 1407 Eastern Ave.		24b. REGISTRAR'S SIGNATURE Arthur L. House	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1672

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1672 CERTIFICATE OF DEATH

01656

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry W. Kellam First Middle Last Served As: Henry W. Kellam		4. DATE OF DEATH Month February Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/18/96
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Packing House	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred D. Kellam		14. MOTHER'S MAIDEN NAME Elizabeth Bunting	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 217-05-9302	
17. INFORMANT Clin. Rec. VAH, Palto. Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO 592x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC GLOMERULONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 10, 1960 , to February 13, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 13, 1960 , and that death occurred at 6:20 P.M. on the causes and on the date stated above.			
22a. SIGNATURE John E. Eisenlohr		22b. DATE SIGNED 2/14/60	
22c. PHYSICIAN'S NAME (Type) JOHN E. EISENLOHR, M.D.		22d. ADDRESS VAH, BALTIMORE, MD, FORT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/18/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips		25a. REC'D BY REGISTRAR DATE FEB 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01657

1673

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Towson</u> <u>1</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>1825 West Baltimore St</u> <u>Baltimore</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 23</u> d. STREET ADDRESS <u>615 Chestnut Ave</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women's & Aged Mens Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kendall, Miss May C</u> First Middle Last		4. DATE OF DEATH <u>Feb 23 1960</u> Month Day Year	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-67</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>chester town, Kent Co Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Arthur Kendall</u>		14. MOTHER'S MAIDEN NAME <u>Laura Glenn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>A1-Haight RN</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>acute leukemia</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>February 23, 1960</u> , that I last saw the deceased alive on <u>February 21st</u> , 1960, and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 E-33rd St Balto 18 Md</u> DATE SIGNED <u>Feb 22 1960</u>			
ACTUAL SIGNATURE <u>Newland E. Day</u>		M.D. <u>4 E-33rd St Balto 18 Md</u>	
PHYSICIAN'S NAME (Type) <u>NEWLAND E. DAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestertown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>		ADDRESS <u>1217 St. Paul Street</u>	
24a. REC'D BY REGISTRAR <u>FEB 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

1917

1917

1917



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01658

1674

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines-16 Fusting Ave.				d. STREET ADDRESS Wilson & Eutaw St. Marlborough Apts.			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET LAUER KERNGOOD				4. DATE OF DEATH Month Day Year Feb. 5th, 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12th 1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John D. Lauer				14. MOTHER'S MAIDEN NAME Katherine Welsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mr. Louis F. Lauer-1507 Windemere Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vas. Accident. 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Malnutrition - marked anemia DUE TO (c) Cardiac Insuff.						INTERVAL BETWEEN ONSET AND DEATH 2-5-60 Dec. 1959 Dec. 1959	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15, 1960 , to Feb. 5, 1960 , that I last saw the deceased alive on Feb. 4, 1960 , and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. Bernard J. Cohen M.D. He Maylander and ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DR. BERNARD J. COHEN He Maylander and							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/60	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Balto., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WIEDEFELD & SON+ 501 E. 22nd Street				24a. REC'D BY REGISTRAR DATE FEB 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Blank]		2. SEX [Blank]		3. AGE [Blank]		4. DATE OF BIRTH [Blank]		5. PLACE OF BIRTH [Blank]	
6. OCCUPATION [Blank]		7. MARITAL STATUS [Blank]		8. COLOR [Blank]		9. RELIGION [Blank]		10. EDUCATION [Blank]	
11. DATE OF DEATH [Blank]		12. TIME OF DEATH [Blank]		13. PLACE OF DEATH [Blank]		14. CAUSE OF DEATH [Blank]		15. MANNER OF DEATH [Blank]	
16. SIGNATURE OF DECEASED [Blank]		17. SIGNATURE OF WITNESS [Blank]		18. SIGNATURE OF PHYSICIAN [Blank]		19. SIGNATURE OF CLERK [Blank]		20. SIGNATURE OF JUDGE [Blank]	

1

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the coroner if the death was sudden and unexpected, or by the medical examiner if the death was due to natural causes. It is to be filled out in the case of all deaths, whether or not the death was due to natural causes, and whether or not the death was sudden and unexpected. It is to be filled out in the case of all deaths, whether or not the death was due to natural causes, and whether or not the death was sudden and unexpected.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1675

01659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex (21)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 Avenal Road		d. STREET ADDRESS 6 Avenal Rd.	
3. NAME OF DECEASED (Type or print) AUGUSTA KOLBE		4. DATE OF DEATH Month February Day 27 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Gardner		14. MOTHER'S MAIDEN NAME Elizabeth Jubb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry Kolbe		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombo-phlebitis, both legs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 15 min 1 mon
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 27, 1948 , to Feb 27, 1960 , that I last saw the deceased alive on Feb 10 , 1960, and that death occurred at 8:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Miceli M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 108 S. Taylor Ave Baltimore 21, Md 2/29/60	
PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D.		Baltimore 21, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/2/60	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Balto., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski		ADDRESS 1407 Eastern Ave.	
24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01660

1676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn		c. LENGTH OF STAY IN 1b 5 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Md. 15-57-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home				d. STREET ADDRESS 5823 Bradley Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATIE M. E. KRIEGER First Middle Last				4. DATE OF DEATH Feb. 8, 1960 19			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1875		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Krieger				14. MOTHER'S MAIDEN NAME Katherine Lütner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		INFORMANT Address Rd. Records Augsburg Home 6811 Campfield			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 53 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Mar 19, 1957 to Feb 8, 1960 that I last saw the deceased alive on Feb 4, 1960 , and that death occurred at 1:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hts. - Balto - 7 inf. - 2 to 6 to		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) Earl L. Chambers		4108 Liberty Hts. - Balto - 9 inf. -					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/11/60	22c. NAME OF CEMETERY OR CREMATORY Immanuel Cem		22d. LOCATION (City, town, or county) (State) Balto. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE P.A. HEEMANN				ADDRESS 6067 HARFORD RD.		24a. REC'D BY REGISTRAR FEB 12 '60	
				24b. REGISTRAR'S SIGNATURE Chas. S. House			

1878

CERTIFICATE OF DEATH

MALE

1878

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1677

CERTIFICATE OF DEATH

Reg. Dist. No.

01661

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 1Yr. 3Mos. 21Das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE SHEPPARD AND ENOCH PRATT HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Andrew Middle Hoffman Last Krug				4. DATE OF DEATH Month February Day 1 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1882	9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent and Teacher				10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Krug				14. MOTHER'S MAIDEN NAME Anna Shinnick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. World War I Serv. Mos. in 1918		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yr + u	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, depressed type						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 10, 1958 to Feb 1, 1960 , that I last saw the deceased alive on Jan 30, 1960 , and that death occurred at 9:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Towson 4, Maryland DATE SIGNED Feb 1, 1960							
ACTUAL SIGNATURE W. W. Elgin M.D.				The Sheppard and Enoch Pratt Hospital Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/3/60		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) WOODLAWN MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MARYLAND				24a. REC'D BY REGISTRAR FEB 3 '60		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Thoma</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THIS IS TO CERTIFY

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES EARL RAY		Male		35		White		None	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
Memphis, Tennessee		May 19, 1928		May 14, 1968		10:10 AM		St. Louis, Missouri	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
Myocardial Infarction		Natural		[Signature]		[Signature]		[Signatures]	
16. MEDICAL HISTORY		17. PRESENT ILLNESS		18. POST-MORTEM EXAMINATION		19. OTHER INFORMATION		20. REMARKS	
Hypertension, Diabetes Mellitus		Sudden onset of chest pain, shortness of breath		None performed		None		None	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERK		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1553

CERTIFICATE OF DEATH

01662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7554 Battle Grove Circle				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAISY Middle MAY Last KYLE				4. DATE OF DEATH Month February Day 4 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1884	
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min. 15		IF UNDER 24 HRS. Months 7 Days 15 Hours 15 Min. 15			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Cole				14. MOTHER'S MAIDEN NAME Lucy Plecher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. R. Pheleps, 3507 McShaneway, Dundalk			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia 480X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Influenza DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A-S-C-V Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) No	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that I attended the deceased from Feb 1 , 19 60 , to Feb 4 , 19 60 , that I last saw the deceased alive on Feb 4 , 19 60 , and that death occurred at 11:14 P.M. , from the causes and on the date stated above. DATE SIGNED M B Davis M.D. ADDRESS (Street, city or town, state) 6800 Morningson Road							
ACTUAL SIGNATURE M B Davis M.D.				M.D. 6800 Morningson Road			
PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D.				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Bradley				ADDRESS Dundalk 22		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1678

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>52</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11 Paradise Ave.</u>			d. STREET ADDRESS <u>11 Paradise Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Harold F. Lacey</u> First Middle Last			4. DATE OF DEATH <u>Feb. 11</u> 19 <u>60</u> Month Day Year		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/01</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>acct.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. R. Grace Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13. FATHER'S NAME <u>James C. Lacey</u>			14. MOTHER'S MAIDEN NAME <u>Clementine Koober</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Catherine Lacey</u>		17. INFORMANT Address <u>Mr. Catherine Lacey</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Geo. H. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>2/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>	
22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGraft & Son</u>		ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR <u>FEB 16 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1. NAME OF DECEASED
JAMES J. HARRIS

2. SEX
Male

3. AGE
45

4. DATE OF DEATH
10/15/1918

5. PLACE OF DEATH
1234 5th Ave., New York City

6. OCCUPATION
Clerk

7. CAUSE OF DEATH
Pneumonia

8. MANNER OF DEATH
Natural

9. SIGNATURE OF MEDICAL EXAMINER
[Signature]

10. SIGNATURE OF DECEASED
[Signature]

11. SIGNATURE OF WITNESSES
[Signatures]

12. SIGNATURE OF CLERK
[Signature]

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1563

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1319 Birch Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Homer S. Middle Landes Last Sr.		4. DATE OF DEATH Month February Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1877
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Landes		14. MOTHER'S MAIDEN NAME Emma Kneely	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-20-7835	
17. INFORMANT Homer S. Landes, Jr.		Address 1319 Birch Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Arteriosclerotic C.V. Disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smoking			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1960 to Feb. 7, 1960 , that I last saw the deceased alive on Feb. 5, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Mac Laughlin M.D.		ADDRESS (Street, city or town, state) 4508 Edmondson Village	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED 2/7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/60	
22c. NAME OF CEMETERY OR CREMATORY Woodbine Cemetery		22d. LOCATION (City, town, or county) (State) Harrisonburg, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc.		24a. REC'D BY REGISTRAR FEB 8 '60	
ADDRESS 1328 Sulphur Spring Rd.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01665

1679

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 29 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (16) 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2402 Westwood Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MELVIN Middle J. Last LANE				4. DATE OF DEATH Month February Day 18 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1913	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter				10b. KIND OF BUSINESS OR INDUSTRY Oil Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Earl Lane				14. MOTHER'S MAIDEN NAME Marie Jennings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 213-10-2257		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) CARCINOMA OF THE LUNG DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from January 20, 1960 to February 18, 1960 , that it (we) last saw the deceased alive on 2/18/1960 , and that death occurred 9:30 A M, from the causes and on the date stated above.							
22a. SIGNATURE <i>W. J. Pijanowski</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/18/60	
22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M.D.				22d. ADDRESS VAH, BALTO. 18, MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>George G. Kelson</i>				ADDRESS 1348 N. Calhoun St. Balto., Md.		25a. REC'D BY REGISTRAR FEB 23 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krawt</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1978

1. Name of Deceased		2. Sex		3. Race	
4. Date of Birth		5. Date of Death		6. Place of Birth	
7. Usual Residence		8. Cause of Death		9. Manner of Death	
10. Signature of Physician		11. Signature of Registrar		12. Signature of Informant	
13. Date of Entry		14. Place of Entry		15. Signature of Informant	
16. Signature of Informant		17. Signature of Informant		18. Signature of Informant	
19. Signature of Informant		20. Signature of Informant		21. Signature of Informant	
22. Signature of Informant		23. Signature of Informant		24. Signature of Informant	
25. Signature of Informant		26. Signature of Informant		27. Signature of Informant	
28. Signature of Informant		29. Signature of Informant		30. Signature of Informant	
31. Signature of Informant		32. Signature of Informant		33. Signature of Informant	
34. Signature of Informant		35. Signature of Informant		36. Signature of Informant	
37. Signature of Informant		38. Signature of Informant		39. Signature of Informant	
40. Signature of Informant		41. Signature of Informant		42. Signature of Informant	
43. Signature of Informant		44. Signature of Informant		45. Signature of Informant	
46. Signature of Informant		47. Signature of Informant		48. Signature of Informant	
49. Signature of Informant		50. Signature of Informant		51. Signature of Informant	
52. Signature of Informant		53. Signature of Informant		54. Signature of Informant	
55. Signature of Informant		56. Signature of Informant		57. Signature of Informant	
58. Signature of Informant		59. Signature of Informant		60. Signature of Informant	
61. Signature of Informant		62. Signature of Informant		63. Signature of Informant	
64. Signature of Informant		65. Signature of Informant		66. Signature of Informant	
67. Signature of Informant		68. Signature of Informant		69. Signature of Informant	
70. Signature of Informant		71. Signature of Informant		72. Signature of Informant	
73. Signature of Informant		74. Signature of Informant		75. Signature of Informant	
76. Signature of Informant		77. Signature of Informant		78. Signature of Informant	
79. Signature of Informant		80. Signature of Informant		81. Signature of Informant	
82. Signature of Informant		83. Signature of Informant		84. Signature of Informant	
85. Signature of Informant		86. Signature of Informant		87. Signature of Informant	
88. Signature of Informant		89. Signature of Informant		90. Signature of Informant	
91. Signature of Informant		92. Signature of Informant		93. Signature of Informant	
94. Signature of Informant		95. Signature of Informant		96. Signature of Informant	
97. Signature of Informant		98. Signature of Informant		99. Signature of Informant	
100. Signature of Informant		101. Signature of Informant		102. Signature of Informant	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 256 2-11-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01666

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN lb 36 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent 1001 West Joppa Rd.		d. STREET ADDRESS 1001 West Joppa Road	
3. NAME OF DECEASED (Type or print) Sister Mary Veronica (Lawlor)		4. DATE OF DEATH Month Feb. Day 1st. Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	9. AGE (In years last birthday) yrs. 18768366
11. BIRTHPLACE (State or foreign country) Broadcove, Newfondland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy Lawlor		14. MOTHER'S MAIDEN NAME Mary Sheehan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Rd. Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Cardiac-Renal DUE TO 10 yrs (c) Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Oct. 1, 19 46 to February 19 60 that I last saw the deceased alive on January 16 19 60 and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Road. DATE SIGNED 2/2/60 ACTUAL SIGNATURE Charles F. O'Donnell, M.D. PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D. 7501 York Road. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 2/4/60 22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery 22d. LOCATION (City, town, or county) (State) 1001 West Joppa Rd. Towson, Md. 23. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemmon ADDRESS 4611 Park Heights, Balto. Md. 24a. REC'D BY REGISTRAR FEB 3 '60 24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		White		1/1/1900		1/1/1950		John Doe, Md.		Heart Disease		Natural		John Doe, M.D.		John Doe, Registrar	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of completion		18. Signature of informant		19. Signature of registrar		20. Signature of physician	
John Doe		Wife		123 Main St.		Baltimore		Md.		21201		1/1/1950		John Doe		John Doe		John Doe	
21. Name of funeral home		22. Address		23. City		24. State		25. Zip		26. Date of funeral		27. Signature of funeral home		28. Signature of registrar		29. Signature of physician		30. Signature of informant	
John Doe		123 Main St.		Baltimore		Md.		21201		1/1/1950		John Doe		John Doe		John Doe		John Doe	

1681

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen, Maryland</u> <u>1231-2</u> d. STREET ADDRESS <u>312 F. East Court Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>Jean</u> Last <u>Lervig</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/57</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10b. KIND OF BUSINESS OR INDUSTRY -----		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roger Junior Lervig</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie Ziegenbein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Rosewood Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition and multiple decubiti ulcers - scalp</u> <u>500x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Acute bronchitis and broncho pneumonia</u> DUE TO (c) ----- INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital hydrocephalus - type not determined - since birth</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/25/57</u> , 19 <u> </u> , to <u>2/4/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2/4/60</u> , 19 <u> </u> , and that death occurred at <u>11:30am</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Butler</u>		ADDRESS (Street, city or town, state) <u>Rosewood St. Training School</u> DATE SIGNED <u>2/4/60</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		<u>Owings Mills, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Feb. 5, 1960</u>	22b. DATE THEREOF <u>Feb. 5, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank D. Newell, Baltimore</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 ~~X~~
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1682
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS Parkville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8615 Oakleigh Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Casimir (CASINNI) Middle L. Last LEWANDOWSKI				4. DATE OF DEATH Month February Day 6 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 4, 1921	
9. AGE (in years last birthday) 38 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Social Security				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stanislaus Lewandowski				14. MOTHER'S MAIDEN NAME Mary Sokolowski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W.2 213-12-2287		17. INFORMANT Mrs. Evelyn Lewandowski, same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED 2/6/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Road #14				24a. REC'D BY REGISTRAR DATE FEB 9 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

1668

FOR STATE
DEPT. OF JUSTICE
WASHINGTON, D. C.
JAN 10 1951

1002

1

TO THE DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
FROM THE ATTORNEY GENERAL
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter with several paragraphs of text, mostly illegible due to the quality of the scan.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1683 CERTIFICATE OF DEATH

01669

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City - (Rural)</i> 13x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shadybrook Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Anton Lueke</i> First Middle Last		4. DATE OF DEATH <i>February 1 1960</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-22-1935</i> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Struct. engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bro. R. R.</i>	
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Frank O Lueke</i>		14. MOTHER'S MAIDEN NAME <i>Mary Carleton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <i>Mrs. Thelma Johnson - Ellicott City, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO <i>Constrictive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio. Vascular-Renal Disease</i> DUE TO (c) <i>3 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 1/2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10.19.56</i> to <i>1.31.60</i> , that (I) (we) last saw the deceased alive on <i>1.3.60</i> , and that death occurred on <i>Feb 1</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>George E. Urban</i>		22b. DATE SIGNED <i>2.1.60</i>	
22c. PHYSICIAN'S NAME (Type) <i>George E. URBAN</i>		22d. ADDRESS <i>805 2nd Ave 28 Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-4-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>London Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mundraft & Son</i> ADDRESS <i>58</i>		25a. REC'D BY REGISTRAR <i>FEB 5 '60</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to contain details about a death, including names, dates, and locations.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb. <u>3701.4</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Armocost Nursing Home</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4 E. Eager St.</u>			
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>LYONS</u> Last <u>LYONS</u> 4. DATE OF DEATH Month <u>Feb.</u> Day <u>25,</u> Year <u>19 60</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Mar. 1, 1869</u> 9. AGE (In years last birthday) <u>90</u> IF UNDER 1 YEAR Months <u>90</u> IF UNDER 24 HRS. Hours <u>90</u> Min. <u>90</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S</u>				13. FATHER'S NAME <u>Christopher C. Ballard</u> 14. MOTHER'S MAIDEN NAME <u>Mary Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Miss Hazel Lyons</u> Address <u>4 E. Eager St.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyposstatic Pneumonia</u> DUE TO <u>Fractured Hip</u> Conditions, if any, which gave rise to immediate cause (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u> (a), stating the underlying cause lost. <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell over railing on own home.</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u> 20c. TIME OF INJURY Month, Day, Year <u>Jan. 7 19 60</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> Hour a. m. <u>---</u> p. m. <u>---</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Baltimore City</u> (County) <u>Md.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>2/26/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crem.</u>		22d. LOCATION (City, town, or county) <u>Balto., Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons</u> ADDRESS <u>Balto 17th</u>				24a. REC'D BY REGISTRAR <u>---</u> DATE <u>FEB 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100-240

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK		COUNTY OF	
CITY OF		TOWN OF	
DECEASED			
DATE OF DEATH			
PLACE OF DEATH			
CAUSE OF DEATH			
MANNER OF DEATH			
AGE			
SEX			
RACE			
EDUCATION			
OCCUPATION			
MARITAL STATUS			
RELIGION			
BIRTH DATE			
BIRTH PLACE			
PARENTS			
SIBLINGS			
MARRIAGE			
CHILDREN			
PREVIOUS ILLNESS			
TREATMENT			
HISTORY			
PHYSICAL EXAMINATION			
LABORATORY EXAMINATION			
TOXICOLOGY			
AUTOPSY			
SIGNATURE			
TITLE			
NOTARY PUBLIC			
COMMISSION EXPIRATION DATE			
FEE			
REMARKS			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01671

1685 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 Stanmore Rd.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore 12			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Paul Middle S. Last MacDonald				4. DATE OF DEATH Month Feb. Day 22 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1900		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY B&O RR		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward G. MacDonald				14. MOTHER'S MAIDEN NAME Cordelia Sprinkle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ----		17. INFORMANT Elizabeth C. MacDonald Address Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with generalized DUE TO (c) metastases							INTERVAL BETWEEN ONSET AND DEATH about 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary insufficiency							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to Feb 22 1960 , that (I) (we) last saw the deceased alive on Feb 23 1960 , and that death occurred at 12 M. from the causes and on the date stated above.							
22a. SIGNATURE M. Paul Byaly		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/23/60			
22c. PHYSICIAN'S NAME (Type) M. Paul Byaly		22d. ADDRESS 3033 W. Wood Ave.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-26-60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd., 12		25a. REC'D BY REGISTRAR DATE FEB 24 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1982

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

1982

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]



UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535



1686
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN Tn X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1830 E. Joppa Rd.</u>				d. STREET ADDRESS <u>1830 E. Joppa Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>D.</u> Middle <u>LOWELL</u> Last <u>MADDEN</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1903</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min.		IF UNDER 24 HRS. Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Henry B. Madden</u>				14. MOTHER'S MAIDEN NAME <u>Mary -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Mildred G. Madden - 1830 E. Joppa Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, old + new</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertensive Art. CV Dis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>8 and 12 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>48</u> , to <u>Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>February 2</u> , 19 <u>60</u> , and that death occurred at <u>12:50 P</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1039 St Paul St</u> <u>2/8/60</u> ACTUAL SIGNATURE <u>Lester A. Wall Jr</u> M.D. <u>Baltimore Md</u> PHYSICIAN'S NAME (Type) <u>LESTER A. WALL JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>2/10/60</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>							
22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. J. Tickener & Sons - Baltimore Md</u>							
24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>							
24b. REGISTRAR'S SIGNATURE <u>Carroll S. Thomas</u>							

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Page 4

death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

1922

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1 M 094 1 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1687

CERTIFICATE OF DEATH

Reg. Dist. No.

01673

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenarm Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister Mary Allowine Mahan</u>		4. DATE OF DEATH Month Day Year <u>February 18 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1890</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston, Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Mahan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cunningham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sister M. Peter Fourier</u>		Address <u>Notch Cliff</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive- cardio-renal vascular disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>February</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>February 18</u> , 19 <u>60</u> , and that death occurred at <u>11.50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7501 York Road Towson 4, Md.</u> DATE SIGNED <u>2/19/60</u>			
ACTUAL SIGNATURE <u>Charles F. McDonnell</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles F. McDonnell M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-20-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NR. TOWSON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Geller</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural Pikesville 8, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kathryn Robb Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Peter</u> Last <u>Marie</u>		4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ellicott City, Maryland U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Peter</u>		14. MOTHER'S MAIDEN NAME <u>Ella Mercer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Camille Marie, Old Court Rd., Pikesville 8, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> 7 years DUE TO (c) <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>apr</u> , 19 <u>56</u> , to <u>8 Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8 Feb</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H. Royse</u>		ADDRESS (Street, city or town state) <u>508 Penitentiary Rd Pikesville 8 Md.</u>	
PHYSICIAN'S NAME (Type) <u>Paul H. Royse, M.D.</u>		DATE SIGNED <u>10 Feb 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beartown, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Havelle, Pikesville 8, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		Baltimore		1689		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson 4		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		55 Towson 4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		330 Aigburth Road		d. STREET ADDRESS		330 Aigburth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ETHEL		Middle GERALDINE		Last MARSHALL		4. DATE OF DEATH Month February 14, 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 5, 1904		9. AGE (In years last birthday) 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						Baltimore		U.S.A.	
13. FATHER'S NAME		Edward Murray		14. MOTHER'S MAIDEN NAME		Ethel Lee Zackerway			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Wm.H. Marshall, 330 Aigburth Road, Towson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		Bronchopneumonia, bilaterally		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Fatty degeneration of liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				19				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/15/60	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)			
CREMATION		2-17-60		Green Mount		Baltimore			
23. FUNERAL DIRECTOR		Wm. Cook-Towson, Inc., 1050 York Road, Towson		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
				FEB 16 '60		Arthur S. Kraus			

675

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF CAUSE
1883

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330 ALBANY ROAD

330 ALBANY ROAD

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville Md.		c. LENGTH OF STAY IN 1b 3 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 McHenry St.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Marie Martin (Nee Brown)		4. DATE OF DEATH Feb. 9th 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Brown		14. MOTHER'S MAIDEN NAME Mary Stein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ** **		16. SOCIAL SECURITY NO. 215-36-8329	
17. INFORMANT Daughter Mrs. Ethel Mathews Pikesville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - Decompensating 443X DUE TO Hypertension + arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO hypostatic pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH 6 mos 2 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15-60 to 2-9-60 , that I last saw the deceased alive on 2-9-60 , and that death occurred at 5-30-60 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 2-10-60			
ACTUAL SIGNATURE James G. Saffell		M.D. Reisterstown Md	
PHYSICIAN'S NAME (Type) James G. Saffell			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 11 60	22c. NAME OF CEMETERY OR CREMATORY Leisters Church Cemetery	22d. LOCATION (City, town, or county) (State) Carrollton Md.
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell Jr.		24a. REG. BY REGISTRAR FEB 12 1960 ADDRESS Westminster, Md.	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1890

City of

No.

1890

Coroner's

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name

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01677

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle F. Last MARTIN				4. DATE OF DEATH Month February Day 24 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/21/77	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent				10b. KIND OF BUSINESS OR INDUSTRY Super Market		11. BIRTHPLACE (State or foreign country) Brooklyn, New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 068-05-8740		17. INFORMANT Address Clin. Rec. VAH, Balto. Md. Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) MYOCARDIAL INFARCTION (c) ARTERIOSCLEROTIC HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While o. m. p. m. Not while o. m. p. m. <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Feb. 23 19 60 , to Feb. 24 19 60 , that we (we) lost saw the deceased alive on Feb. 24 19 60 , and that death occurred at 1:45 PM from the causes and on the date stated above.							
22a. SIGNATURE Lawrence D Marcus M.D.				22b. DATE 2/24/60		22c. PHYSICIAN'S NAME (Type) LAWRENCE D. MARCUS, M.D.	
22d. ADDRESS VAH, BALTIMORE, MD. FORT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-27-60		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE FLYNN & FLEMING, INC.				25a. REC'D BY REGISTRAR FEB 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1692 CERTIFICATE OF DEATH

01678

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 976 MASEFIELD RD.				d. STREET ADDRESS 526 ALLENDALE ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANNA M. MASK				4. DATE OF DEATH Month Day Year FEB. 26, 1960			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 5, 1891	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY D.H.		11. BIRTHPLACE (State or foreign country) IRELAND.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CARNEY				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address JOSEPH MASK, 976 MASEFIELD RD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSEPTIC CARDIO 422.1 DUE TO VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2+ YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1945 to 2/26, 1960 that I last saw the deceased alive on 2/25 , 19 60 and that death occurred at 8 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Phyllis E. Poach M.D. 3629 Edmonson Ave 2/29/60							
PHYSICIAN'S NAME (Type) Thos E Poach Balto-29-Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/29/60		22c. NAME OF CEMETERY OR CREMATORY LODON PARK		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE FUNERAL DIR. 4101 EDMONSON AVE				24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. [unclear]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)		c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Middle River (20)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 40 Stabilizer Drive				d. STREET ADDRESS 40 Stabilizer Drive			
3. NAME OF DECEASED (Type or print) First L. WELDON Middle McALLEN, Jr. Last				4. DATE OF DEATH Month February Day 17th Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1911		9. AGE (In years last birthday) 48 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Study		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME L. Weldon McAllen, Sr.				14. MOTHER'S MAIDEN NAME Laura Fuller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-10-3160		17. INFORMANT Address Frances D. McAllen same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V Disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2/19/60			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 2/20/60		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Jr.		ADDRESS Dundalk 22		24a. REC'D BY REGISTRAR DATE FEB 23 60			
24b. REGISTRAR'S SIGNATURE Charles L. Kraus							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED (G) LINDO		AGE 120		SEX MALE		RACE WHITE		DATE OF DEATH 12-10-1913		PLACE OF DEATH HOME	
RESIDENCE 1021 N. E. ST.		CITY BALTIMORE		COUNTY JOHNS HOPKINS		STATE MD		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH 12-10-1913		PLACE OF BIRTH MD		MARRIAGE YES		EDUCATION 8		RELIGION ROMAN CATHOLIC		MANNER OF DEATH NATURAL	
PREVIOUS ILLNESS HEART DISEASE		TREATMENT DRUGS		DIET PLAIN		SMOKING YES		ALCOHOL YES		OTHER NO	
SIGNATURE OF EXAMINER J. H. HARRIS		DATE 12-10-1913		PLACE BALTIMORE		COUNTY JOHNS HOPKINS		STATE MD		FEE 10	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1694

CERTIFICATE OF DEATH

Reg. Dist. No.

01680

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Downs Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elmer E.</u> Middle <u>McCoy</u> Last <u>McCoy</u>		4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18 1868</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>9</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cutter Operator Paper Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lancaster Co., Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John M. McCoy</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>218-26-1734</u>	
17. INFORMANT <u>Mrs. Margaret McCoy</u> Address <u>Parkton, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arterio-sclerotic Cardio-vascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Feb. 4</u> 19 <u>60</u> to <u>Feb. 5</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 4</u> 19 <u>60</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>2/6/60</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) <u>Freeland Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartman</u> ADDRESS <u>New Freedom, B.</u>		24. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

1. Name of deceased: *John F. Smith*
2. Sex: *Male*
3. Date of birth: *Jan 15 1880*
4. Place of birth: *Worcester, Mass.*
5. Date of death: *Dec 10 1950*
6. Place of death: *Worcester, Mass.*
7. Cause of death: *Heart failure*
8. Duration of illness: *2 weeks*
9. Name of attending physician: *Dr. J. H. Brown*
10. Name of funeral home: *John F. Smith & Co.*
11. Name of undertaker: *John F. Smith & Co.*
12. Name of cemetery: *Worcester Rural Cemetery*
13. Name of interment: *John F. Smith*
14. Name of registrar: *John F. Smith*
15. Name of registrar's office: *Worcester, Mass.*

CERTIFICATE OF DEATH

01681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>25 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of the Pines</u>				d. STREET ADDRESS <u>3459 Keswick Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lela</u> Middle <u>H.</u> Last <u>McFadden</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 10-, 9, 0</u>	
9. AGE (In years last birthday) <u>49 yrs.</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>		IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charwoman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Francis McFadden</u>				14. MOTHER'S MAIDEN NAME <u>Michaels</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO. <u>220-07-2501</u>		17. INFORMANT <u>Blanch McFadden</u> Address <u>3459 Keswick Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>416X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease</u> DUE TO <u>30yr.</u> (c) <u>24hr.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24hr.</u> <u>30yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>2-8-</u> , 19 <u>60</u> , to <u>2-9-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-9-</u> , 19 <u>60</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				ADDRESS (Street, city or town, state) <u>6209 Freedom Ave.</u>			
DATE SIGNED <u>2-11-60</u>							
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				<u>Baltimore-28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 12-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Calundann</u>				ADDRESS <u>5646 Carville Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>							

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. SMITH		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15, 1890		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Clerk		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH Dec 10, 1955		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN J. H. Smith	
16. SIGNATURE OF REGISTRAR J. H. Smith		17. SIGNATURE OF WITNESS J. H. Smith		18. SIGNATURE OF WITNESS J. H. Smith		19. SIGNATURE OF WITNESS J. H. Smith		20. SIGNATURE OF WITNESS J. H. Smith	

100-100000-1000

100-100000-1000

Item 9 Film 257 3-2-60 et 1696 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01682

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Convent of the Mission Helpers of the Sacred Heart		d. STREET ADDRESS 1001 West Joppa Road	
3. NAME OF DECEASED (Type or print) Sister Mary Evangelista (McGovern)		4. DATE OF DEATH Feb. 26, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent	
11. BIRTHPLACE (State or foreign country) Trenton, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis McGovern		14. MOTHER'S MAIDEN NAME Honora McCarthy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Rd. Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 722.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Chronic Rheumatoid Arthritis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/30 , 19 59 , to 1/30 , 19 60 that I last saw the deceased alive on 1/30 , 19 60 , and that death occurred at 12:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Wainwright		DATE SIGNED FEB 26 1960	
PHYSICIAN'S NAME (Type) Charles W. Wainwright, M.D.		9 East Chase St. Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/29/60	22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery	22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemmon		ADDRESS 4611 Park Heights A. Balto.	
24a. REC'D BY REGISTRAR FEB 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 4, 5, 6, 7, and 8 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
John A. Smith		Male		45	
Place of birth		Date of birth		Date of death	
Boston, Mass.		Jan. 1, 1880		Jan. 1, 1925	
Cause of death		Disease		Occupation	
Heart disease		Myocardial infarction		Clerk	
Period of illness		Place of death		Signature of physician	
One week		Boston, Mass.		J. B. Doe, M.D.	
Signature of informant		Relationship		Signature of registrar	
J. B. Doe		Son		J. B. Doe	
Address of informant		Address of deceased		Address of registrar	
100 N. Main St., Boston, Mass.		100 N. Main St., Boston, Mass.		100 N. Main St., Boston, Mass.	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Film 258
3-10-60 am

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01683

1. PLACE OF DEATH e. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Abandoned railway track to Ellicott City					
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First GEORGE Middle THOMAS Last McKINZE			Month February Day 16 Year 1960		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-2-1908		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Howard Co. Md	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-6196		17. INFORMANT Mrs. Mary Knisley, Guilford, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcohol intoxication 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) 322.0 (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exposure to freezing temperature					INTERVAL BETWEEN ONSET AND DEATH -
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Peter W. Rieckert		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/17/60	
EXAMINER'S NAME (Type) Peter Rieckert, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-19-1960		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	
22d. LOCATION (City, town, or country) Ellicott City, Md		(State)			
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR FEB 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause					

5/11/10 11:00 AM

2-12-1980 Doc. 119494

of the tropics, no doubt.

01684

MEDICAL CERTIFICATION

VS A1S (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

72

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1699

CERTIFICATE OF DEATH

Reg. Dist. No.

01685

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 97 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2764 Tivoly Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LLOYD Middle W. Last MELVIN				4. DATE OF DEATH Month February Day 2 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 14, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Collector-Retired U. S. Government				10b. KIND OF BUSINESS OR INDUSTRY Customs			
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John W. Melvin				14. MOTHER'S MAIDEN NAME Lillie Mae Decker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 218-367-692			
17. INFORMANT Clin. Records, VAH, Baltimore 18, Md. Ft. Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491x EXACT Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) CARCINOMA OF LUNG WITH METASTASIS (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 28, 1959 to February 2, 1960 , that I last saw the deceased alive on February 2, 1960 , and that death occurred at 10:00 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter C. Goldstein				ADDRESS (Street, city or town, state) DATE SIGNED VAH, BALTO. 18, MD. FT. HOWARD DIVISION 2/2/60			
PHYSICIAN'S NAME (Type) WALTER C. GOLDSTEIN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/5/60			
22c. NAME OF CEMETERY OR CREMATORY Baltimore National				22d. LOCATION (City, town, or county) (State) Baltimore Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				24a. REC'D BY REGISTRAR FEB 3 '60			
ADDRESS 5005 Harford Rd., Balto. Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Conclusions

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Index

1. The first step is to identify the problem or question that needs to be answered.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1700

CERTIFICATE OF DEATH

Reg. Dist. No.

01686

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr11mth15days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle A. Last Merritt		4. DATE OF DEATH Month February Day 23 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1880
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homewife		10b. KIND OF BUSINESS OR INDUSTRY O. H.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Schue		14. MOTHER'S MAIDEN NAME Melvina	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15, 1958 to Feb. 23, 1960 that I last saw the deceased alive on Feb. 23, 1960 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 2-23-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/27/60	
22c. NAME OF CEMETERY OR CREMATORY St. Matthews		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE FEB 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

11780

CERTIFICATE OF DEATH

1900

Blank certificate form with faint lines and text, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through from the reverse side.

State of New York

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1701 CERTIFICATE OF DEATH

01687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>15yrlmthl7dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>48 Market Place</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle Last <u>Michaels</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 16, 1892</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Michaels</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Walters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-01-1610</u>			
17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Cardiac failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the nose</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 3</u> , 19 <u>51</u> , to <u>Feb. 19</u> , 19 <u>60</u> , that I lost sows the deceased alive on <u>Feb. 19</u> , 19 <u>60</u> , and that death occurred at <u>4:00a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachler</u>				ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>2-19-60</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachler, M. D.</u>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>4300 eed Frederic</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley & Sons</u> ADDRESS <u>1318 Light</u>				24a. REC'D BY REGISTRAR <u>FEB 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1701

CERTIFICATE OF DEATH

THE STATE OF NEW YORK

County of _____

City of _____

State of _____

1702 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2111 Northland Rd.		d. STREET ADDRESS 2111 Northland Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAURA C. MILLER		4. DATE OF DEATH Month Feb. Day 6 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1876
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown/ Thomas Howard		14. MOTHER'S MAIDEN NAME Unknown/ Margaret Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Marie C. Marks - 2111 Northland Rd. #7		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5 , 19 50 , to Feb 6 , 19 60 , that I last saw the deceased alive on Feb 5 , 19 60 , and that death occurred at 4:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1039 St Paul St DATE SIGNED 2/6/60 ACTUAL SIGNATURE Lester A. Wall Jr M.D. PHYSICIAN'S NAME (Type) LESTER A. WALL JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - North 17th		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1700

1



1



1703 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Nova, Balto. 7		c. LENGTH OF STAY IN 1b About 4 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robba Nursing Home, Essex Road,		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) Agnes Sander Moll		4. DATE OF DEATH Month February Day 17 Year 1960	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIAGE STATUS WIDOWED	8. DATE OF BIRTH October 1, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Marietta, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Sander		14. MOTHER'S MAIDEN NAME Margaret Kock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. John S. Moll		Address 3716 Campfield Road, Balto. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/48 , 19 60 , to 2/17 , 19 60 , that I last saw the deceased alive on 2/17 , 19 60 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward S. Kalline		ADDRESS (Street, city or town, state) 4300 Liberty Heights Ave. DATE SIGNED 2/19/60	
PHYSICIAN'S NAME (Type) Dr. Edward S. Kalline		4300 Liberty Heights Ave., Balto. Balto. 7	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/19/60	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Road Randallstown, Md.	
24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

TIME OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Baltimore		Essex		Maryland		Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
960 Middlesex Rd.				960 Middlesex Rd.			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
DAVID M MORRIS				February 25 1960			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White				Oct. 31, 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Child				Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Nicholas W. Morris				Terry Amey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
						Mr. Nicholas W. Morris, same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Pneumonia							
493X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
William V. Lovitt, Jr., M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED							
2/25/60							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		2/27/60		Woodlawn Cemetery		Baltimore, Maryland	
23. FUNERAL DIRECTOR ADDRESS				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
Leonard J. Ruck 5305 Harford Road. #14				DATE MAR 1 '60 Arthur S. Kline			

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CERTIFICATE OF DEATH

Reg. Dist. No.

01691

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUXTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUXTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1201 BERWICK AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDMUND TILESTON MUDGE II				4. DATE OF DEATH Month Day Year 2 27 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-95	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10b. KIND OF BUSINESS OR INDUSTRY WHOLESALE PAPER		11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FRANK MUDGE				14. MOTHER'S MAIDEN NAME MARGARET LOUISE SIMON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 214-03-5335		17. INFORMANT Address E.T. MUDGE III 1208 JOHN ST. BALTO, MO			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Venous 445 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malignant hypertension (c) arterio- & arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 9 mos sev. yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1953 , to present , that I last saw the deceased alive on Feb 27 , 19 60 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1101 N. Calvert St, Balto DATE SIGNED 2/28/60 ACTUAL SIGNATURE Ernest C. Brown Jr M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-29-60	22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE	22d. LOCATION (City, town, or county) PIKESVILLE	(State) MO.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.W. JENKINS & SONS CO. 4905 YORK RD. BALTO. MO			24a. REC'D BY REGISTRAR MAR 2 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1706 CERTIFICATE OF DEATH

01692

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex (21)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>212 S. Margaret Ave.</u>		d. STREET ADDRESS <u>212 S. Margaret Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>BRIDGET (MUDINISKI) MUDINKA</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 1, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Helen Ziemba</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Respiratory failure</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). <u>Cerebral thrombosis</u> DUE TO (c). <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>17. weeks</u> <u>1 wk.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Arteriosclerotic heart disease with failure.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>59</u> , to <u>1/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>60</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Platt</u>		ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u>	
PHYSICIAN'S NAME (Type) <u>J. PLATT, M.D.</u>		DATE SIGNED <u>Easy md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Belto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bruzdziński</u>		ADDRESS <u>1407 Eastern Ave.</u>	
24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kura</u>	

1554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3107 Ardee Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maybelle E. Murray Middle E. Last Murray		4. DATE OF DEATH Month Feb. Day 16, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1884
9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Hall		14. MOTHER'S MAIDEN NAME Catherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Wm. J. Murray 3107 Ardee Way-22	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension C-V. Disease DUE TO 13 yrs. (c)		INTERVAL BETWEEN ONSET AND DEATH 3 m	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Accident = 1947		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1947 , 19 60 to Feb 16 , 19 60 , that I last saw the deceased alive on Feb 16 , 19 60 , and that death occurred at 17:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M. B. Davis M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 6800 Mornington Rd - 2/18/60	
PHYSICIAN'S NAME (Type) M. B. DAVIS M.D.		Dundalk - 22 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/19/60	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR FEB 23 '60	24b. REGISTRAR'S SIGNATURE Charles E. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

1. Name of deceased: John Doe

2. Age: 45

3. Sex: Male

4. Date of birth: Jan 15, 1856

5. Date of death: Dec 10, 1901

6. Place of death: Home

7. Cause of death: Heart Disease

8. Signature of physician: Dr. J. H. Smith

9. Signature of registrar: W. D. Jones

10. Signature of informant: John Doe

1 1707 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01694

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3031 Edgewood Ave.</i>		d. STREET ADDRESS <i>13031 Edgewood Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>Mr. George</i> Middle <i>W.</i> Last <i>Nelson</i>		4. DATE OF DEATH Month <i>February</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-15-1884</i>
9. AGE (In years last birthday) yrs. <i>75</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Maintenance man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Nelson</i>	
14. MOTHER'S MAIDEN NAME <i>Longemann</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>217-03-1913</i>		INFORMANT Address <i>Catherine Bender 8502 James Ave. 14</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>Arteriosclerotic (cardio-vascular) disease</i> DUE TO (c) <i>540.1</i>			INTERVAL BETWEEN ONSET AND DEATH <i>perman.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <i>July</i> , 19 <i>55</i> , to <i>Feb.</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Feb. 14</i> , 19 <i>60</i> , and that death occurred at <i>2:10 P.M.</i> from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Robert Sparks</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>200 Harford Rd., Balt. Md. 2/15/60</i>	
PHYSICIAN'S NAME (Type)		22a. REC'D BY REGISTRAR DATE <i>FEB 18 '60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>2-18-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>
22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>	
24a. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

No.	Name	Address	City	State	County	Assessed Value	Amount of Tax	Amount of Interest	Amount of Penalties	Amount of Total
1	John Doe	123 Main St.	Chicago	Ill.	Cook	1000.00	10.00	0.00	0.00	10.00
2	Jane Smith	456 Oak St.	Chicago	Ill.	Cook	2000.00	20.00	0.00	0.00	20.00
3	Robert Brown	789 Elm St.	Chicago	Ill.	Cook	3000.00	30.00	0.00	0.00	30.00
4	Mary White	101 Maple St.	Chicago	Ill.	Cook	4000.00	40.00	0.00	0.00	40.00
5	James Green	202 Pine St.	Chicago	Ill.	Cook	5000.00	50.00	0.00	0.00	50.00
6	William Black	303 Cedar St.	Chicago	Ill.	Cook	6000.00	60.00	0.00	0.00	60.00
7	Elizabeth Gray	404 Birch St.	Chicago	Ill.	Cook	7000.00	70.00	0.00	0.00	70.00
8	Thomas King	505 Walnut St.	Chicago	Ill.	Cook	8000.00	80.00	0.00	0.00	80.00
9	Sarah Lee	606 Spruce St.	Chicago	Ill.	Cook	9000.00	90.00	0.00	0.00	90.00
10	Charles Hall	707 Ash St.	Chicago	Ill.	Cook	10000.00	100.00	0.00	0.00	100.00

CERTIFICATE OF DEATH

Reg. Dist. No.

01695

1708

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>13 wks</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>J.</u> Last <u>Newell, Sr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN THE PINES NURSING & CONVALESCENT HOME</u>				d. STREET ADDRESS <u>120 N. HILTON ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1960</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED STATIONARY ENGINEER NATIONAL BREWERY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>MICHAEL NEWELL</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE A. BURKE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-05-4070</u>		17. INFORMANT <u>MRS. CATHERINE EBBERT</u>		Address <u>15 LINWOOD DR, ELLICOTT CITY, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Hypertension Cardio-Vascular Disease</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-30-1959</u> to <u>2-9-1960</u> , that I last saw the deceased alive on <u>2-9-1960</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>2-9-60</u>							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				M.D. <u>6209 Frederick Ave.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				Baltimore-28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-13-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Walter Conklin</u>				ADDRESS <u>5444 BELAIR RD, BALTO.</u>		24a. REC'D BY REGISTRAR <u>Feb 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1709 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Baltimore (27)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Nitkiewicz</u> Last				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18th</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29th 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Poland</u> ✓							
13. FATHER'S NAME <u>Grzywna</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>William Rojsza</u> Address <u>5511 Council St.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cardio-Vascular Disease</u> DUE TO (c) <u>Cardio-Vascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Left Breast 1954. Rt Breast 1958</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/15</u> , 19 <u>52</u> , to <u>2/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>60</u> , and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eliot W. Johnson</u>				ADDRESS (Street, city or town, state) <u>3432 Frederick Ave</u>			
DATE SIGNED <u>2/19/60</u>							
PHYSICIAN'S NAME (Type) <u>Eliot W. Johnson</u>				<u>Baltimore 29 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Water Dolorosa</u>		22d. LOCATION (City, town, or county) (State) <u>South Hadley Cent Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber Jr.</u> ADDRESS <u>5614 Carville Ave</u>				24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Harris</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1710 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Y			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER				c. LENGTH OF STAY IN 1b 6 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 090 IVY HALL NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES H. NORANBROCK, SR.				4. DATE OF DEATH FEB. 26 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 24, 1870	
9. AGE (In years last birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER - WOMBLE Lumber		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 216-18-4829			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 10 YRS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work _____ Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 6/8 , 19 54 to 2/26 , 19 60 that I last saw the deceased alive on 2/26 , 19 60 , and that death occurred at 1 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Benjamin H. Hirstein M.D.				ADDRESS (Street, city or town, state) 121 S. HIGHLAND AVE. BALTO. MD.			
PHYSICIAN'S NAME (Type) B. H. HIRSTEIN				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 1, 1960		22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL		22d. LOCATION (City, town, or county) BALTO. (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. W. Hoffmann ADDRESS 3218 HUDSON ST.				24a. REC'D BY REGISTRAR FEB 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE CERTIFICATE OF DEATH

BALTO

MD

MIDDLE RIVER

BALTO CITY

1711 HALL WALKING HOME

1111 S. HIGHLAND AVE

CHARLES H. HORNBERGER, JR.

FE0 32

WHITE WHITE

W

BY

WAGONER - WAGONER, MD

1004

NOT KNOWN

NOT KNOWN

2111 1/2 ED. HORNBERGER, JR. HOS. 2111 1/2

ALLEN D. HORNBERGER, JR. HOS. 2111 1/2

2111 1/2

2111 1/2

2111 1/2

2111 1/2

2111 1/2

2111 1/2

CERTIFICATE OF DEATH

01698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Glenarm Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Ethel North</u>		4. DATE OF DEATH <u>Feb 23</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hom.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elias & Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Husband</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial ischemia</u> <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis and degeneration</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>5+ yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 14</u> , 19 <u>56</u> , to <u>Feb 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 14</u> , 19 <u>60</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 HARTFORD RD BALTO 14 Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK JR.</u>		DATE SIGNED <u>2/23/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>227-60</u>		22b. DATE THEREOF <u>227-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard Kuch</u> ADDRESS <u>5305 Hurlst</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES H. HARRIS		Male		45		1901		Baltimore, Md.		Carpenter		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
April 15, 1948		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris	
17. PLACE OF INTERMENT		18. NAME OF INTERMENT		19. DATE OF INTERMENT		20. NAME OF INTERMENT		21. NAME OF INTERMENT		22. NAME OF INTERMENT		23. NAME OF INTERMENT		24. NAME OF INTERMENT	
St. Mary's Cemetery		St. Mary's Cemetery		April 18, 1948		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery		St. Mary's Cemetery	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death.

2. The cause of death should be stated in full, and the manner of death should be stated as natural, accidental, or suicidal.

3. The place of death should be stated as home, hospital, or other place.

4. The date and time of death should be stated.

5. The name of the physician or other qualified person who has attended the deceased or who has been informed of the cause of death should be stated.

6. The name of the registrar should be stated.

7. The name of the witnesses should be stated.

8. The name of the place of interment should be stated.

9. The name of the interment should be stated.

10. The date of interment should be stated.

11. The name of the interment should be stated.

12. The name of the interment should be stated.

13. The name of the interment should be stated.

14. The name of the interment should be stated.

15. The name of the interment should be stated.

16. The name of the interment should be stated.

17. The name of the interment should be stated.

18. The name of the interment should be stated.

19. The name of the interment should be stated.

20. The name of the interment should be stated.

21. The name of the interment should be stated.

22. The name of the interment should be stated.

23. The name of the interment should be stated.

24. The name of the interment should be stated.

1712 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westview				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westview			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1333 Dillion Hgts. Ave.				d. STREET ADDRESS 1333 Dillion Hgts. Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Helen M. Middle Nunnold Last				4. DATE OF DEATH Month 2/1/60 Day Year 19			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/19/1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Goodman				14. MOTHER'S MAIDEN NAME Anna			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address George Nunnold 1333 Dillion Hgts. Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smoking							INTERVAL BETWEEN ONSET AND DEATH 7 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to Feb 1 1960 , that I last saw the deceased alive on Jan. 30 1960 , and that death occurred at 8 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Dr. D.C. McLaughlin M.D.				4508 Edmonson Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/5/60		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave. 29		24a. REC'D BY REGISTRAR DATE FEB 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

2015

9VA 2024 201115782

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01700

1555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. 3101 Vulcan Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rose Middle Anna Last Oberholtzer				4. DATE OF DEATH Month February Day 2 Year 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Krenz				14. MOTHER'S MAIDEN NAME Margaret Weimer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Margaret Pearson 3101 Vulcan Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) Chronic Congestive Heart Failure							INTERVAL BETWEEN ONSET AND DEATH 2 days, 10 years,
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1958 to Feb 2, 1960 , that I last saw the deceased alive on Jan 30, 1960 , and that death occurred at 4:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Roger G. Windsor, M.D.				ADDRESS (Street, city or town, state) 520 St. Spencerville, Md 2360			
DATE SIGNED FEB 19, 1960							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel		22d. LOCATION (City, town, or county) (State) Columbia, Pa. Lanc. Co.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22, Md.				24a. REC'D BY REGISTRAR DATE FEB 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The death certificate is to be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1713 CERTIFICATE OF DEATH

01701

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 62yr8mths	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. NAME OF DECEASED (Type or print) First Frank Middle Ott Last Ott	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 234 South Bouldin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month FEB Day 27 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875 (?) AUG 22
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Arteriosclerotic Cardiovascular Disease years Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO Generalized Arteriosclerosis years (c) Schizophrenic reaction chronic undiffer. type			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 17 , 19 60 , to FEB 27 , 19 60 , that I last saw the deceased alive on Feb 27th , 19 60 , and that death occurred at 9:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2/27/60			
ACTUAL SIGNATURE Bruno Radauskas		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/29/60	22c. NAME OF CEMETERY OR CREMATORY John J. Connelly	22d. LOCATION (City, town, or county) (State) Taylor Ave. Balto Co.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly Esq - Ind.		24a. REC'D BY REGISTRAR DATE MAR 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH

RECEIVED
FEB 10 1964
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Signature of medical officer: [illegible]
7. Signature of coroner: [illegible]
8. Signature of registrar: [illegible]
9. Date of registration: [illegible]
10. Place of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01702

1714 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville		MARYLAND c. LENGTH OF STAY IN 1b 73 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville		d. STREET ADDRESS 3207 Rolling Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Celia		First Celia		Middle Pahl		Last Pahl		4. DATE OF DEATH Month February Day 5 Year 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1872		9. AGE (In years last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Andrew Askar				14. MOTHER'S MAIDEN NAME Eleanor Sank					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. J. Harry Subock Address 3207 Rolling Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. disease - arteriosclerosis (c) Stroke - 2 per. cerebral vas. accidents								INTERVAL BETWEEN ONSET AND DEATH 1 day 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 2, 1950 , to Feb 5, 1960 , that I last saw the deceased alive on Feb 5, 1960 , and that death occurred at 7 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas E. Wheeler M.D. 3601 Clifmar Road Baltimore 7, Md.									
ACTUAL SIGNATURE Thomas E. Wheeler M.D. 3601 Clifmar Road Baltimore 7, Md.									
PHYSICIAN'S NAME (Type) Dr. Thos. E. Wheeler 3601 Clifmar Road Baltimore 7, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 8, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS 8728 Liberty Rd. Randallstown Md.		24a. REC'D BY REGISTRAR FEB 12 '60		24b. REGISTRAR'S SIGNATURE Chas. S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER	
23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER	
27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER	
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47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER	
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99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

1715

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01703

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River c. LENGTH OF STAY IN 1b 54		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. d. STREET ADDRESS 2 Maple Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle HALL Last PECK		4. DATE OF DEATH Month Feb. Day 25 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1906 9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Specialist		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) R. I.		12. CITIZEN OF WHAT COUNTRY? R. I.	
13. FATHER'S NAME Horace Sill Peck		14. MOTHER'S MAIDEN NAME Gertrude Tuller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Barbara White Peck - 2 Maple Drive		Address Middle River, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL INSUFFICIENCY 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC PYELONEPHRITIS + NEPHROLITHIASIS, BILAT. (c) 20 YRS INTERVAL BETWEEN ONSET AND DEATH 7 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 19 49 to Feb 25, 1960 , that (I) (we) lost the deceased on Feb 25, 1960 , and that death occurred at 8:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Louis Semenov		22b. DATE SIGNED 2/26/60	
22c. PHYSICIAN'S NAME (Type) LOUIS SEMENOFF		22d. ADDRESS 2108 CRENS RD, BALTO 20, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 2/27/60	23c. NAME OF CEMETERY OR CREMATORY Green Mount Crem.	23d. LOCATION (City, town, or county) (State) Balto., Md.
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto 17		25a. REC'D BY REGISTRAR DATE FEB 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Krasa			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
STATE OF NEW YORK
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

INDUSTRY

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

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1564 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 51 Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1821 Arbutus Avenue		d. STREET ADDRESS 1821 Arbutus Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Emory Last Peddicord		4. DATE OF DEATH Month Feb. Day 26 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1888
9. AGE (In years lost birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock	
11. BIRTHPLACE (State or foreign country) Elkridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer E. Peddicord		14. MOTHER'S MAIDEN NAME Mary E. Coates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-6935	
17. INFORMANT Alice L. Peddicord		Address 1821 Arbutus Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr Myocarditis 422.1 DUE TO Dehydration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr Bronchitis DUE TO General Arteriosclerosis (c) Chr Neurodermatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr Neurodermatitis INTERVAL BETWEEN ONSET AND DEATH 8 mo 3 mo 7 1/2 5 1/2			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 19 59 to Feb 26 1960 , that I last saw the deceased alive on Feb 25, 1960 , and that death occurred at 1821 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2-27/60			
ACTUAL SIGNATURE Bruce Brumbaugh M.D.			
PHYSICIAN'S NAME (Type) Bruce Brumbaugh, M.D.		5609 Main Street, Elkridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/29/60	
22c. NAME OF CEMETERY OR CREMATORY Grace Episcopal Cem.		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR FEB 29 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> 1715 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b 		d. STREET ADDRESS <u>1741 Glen Ridge Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1741 Glen Ridge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter E. Perkins</u>				4. DATE OF DEATH Month Day Year <u>Feb. 1, 19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Colonel</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-34-5379</u>		17. INFORMANT Address <u>Mrs. Mary M. Perkins, 1741 Glenridge</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>974x</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Depression</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John C. Hyle</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>				DATE SIGNED <u>2-2-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Feb. 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Rd</u>				24a. REC'D BY REGISTRAR <u>FEB 3 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Journal of Management Education 30(6)

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CERTIFICATE OF DEATH

Reg. Dist. No. 32

1717

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson, Maryland</u>		<u>11 months</u>		TOWN <u>ANNAPOLIS</u>		<u>0210-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>1023 MADISON STREET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>VINCENT</u> (Last) <u>PHIPPS</u>				(Month) <u>2</u> (Day) <u>29</u> (Year) <u>1960</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>7/9/17</u>	<u>42</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MUSIC MACHINE MECHANIC</u>				<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME <u>HORACE E. PHIPPS</u>				14. MOTHER'S MAIDEN NAME <u>BEULAH JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-14-2090</u>		17. INFORMANT & ADDRESS <u>Hospital Records, Mt. Wilson State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X IMMEDIATE CAUSE (A) <u>PULMONARY TUBERCULOSIS</u>						<u>2 1/2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ENLARGEMENT OF HEART due to PULMONARY DISEASE 1 YEAR</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
				<u>1959</u>			
22. I hereby certify that I attended the deceased from <u>3/10</u> , 19 <u>59</u> , to <u>2/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>60</u> , and that death occurred at <u>1230</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>ANNAPOLIS MD.</u>			
DATE SIGNED <u>Mar 3 60</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-3-60</u>		<u>HILLCREST</u>		<u>ANNAPOLIS MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>MAR 3 60</u>		<u>Charles S. Kraus</u>		<u>John M. Taylor & Sons</u>		<u>ANNAPOLIS MD.</u>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ma. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville 28	
d. NAME OF HOSPITAL (If not in hospital, give street address) 970 St. Agnes Lane		d. STREET ADDRESS 970 St. Agnes Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James H. Plunkert, Sr. Middle Last		4. DATE OF DEATH Feb. 6/60 Day Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29/92
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co. Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Geo. W. Plunkert		14. MOTHER'S MAIDEN NAME Louisa Krah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215 09 3816	
INFORMANT Mrs. Bertha E. Plunkert, 970 St. Agnes Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/10 , 19 59 , to 2/6 , 19 60 , that I last saw the deceased alive on 2/6 , 19 60 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morton M. Krieger		ADDRESS (Street, city or town, state) 2108 Eutaw Place DATE SIGNED 2/7/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/9/60	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore 29 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01217

RECEIVED - NEW YORK OFFICE OF HEALTH - BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

118

Baltimore

Patersonville

970 St. James Lane

970 St. James Lane

Feb. 6/60

James L. Plummer, Jr.

X

White

Male

27

Sept. 29/92

USA

Baltimore, Maryland

Retired

James L. Plummer

James L. Plummer

115 03 2815 Mrs. Martha M. Plummer, 970 St. James Lane

Baltimore, Md.

New Hospital

2/9/60

Female

White, Married, 45 years

01708

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastwood		c. LENGTH OF STAY IN lb Eastwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7260 Stratton Way # 24		d. STREET ADDRESS 7260 Stratton Way	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle GEORGE Last PODRAZA		4. DATE OF DEATH Month February Day 21 Year 1960.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24 - 07
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevendore		10b. KIND OF BUSINESS OR INDUSTRY I.L.A. Union.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph PODRAZA	
14. MOTHER'S MAIDEN NAME Eva Kot		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 217-05-7511		17. INFORMANT Annette V. Podraza Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Hypertension C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension C.V. Disease DUE TO (c) Hypertension C.V. Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		DATE SIGNED 2/22/60	
EXAMINER'S NAME (Type) M. B. Davis MD.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-60.	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler		ADDRESS 901 S. CONKLING ST. BALTO. 24, MD.	
24a. REC'D BY REGISTRAR DATE FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR STATE
HEALTH DEPT

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1919

NAME OF DECEASED: JOHN J. BROWN
AGE: 45 SEX: MALE
DATE OF DEATH: 10-15-1919 PLACE OF DEATH: HOME
RESIDENCE: 123 MAIN ST. BOSTON, MASS.
CAUSE OF DEATH: HEART DISEASE
MANNER OF DEATH: NATURAL
SIGNATURE OF EXAMINER: [Signature]
OFFICE OF EXAMINER: BOSTON
DATE OF EXAMINATION: 10-16-1919
LOCAL HEALTH OFFICER: [Signature]
LOCAL HEALTH OFFICE: BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1720 CERTIFICATE OF DEATH

Reg. Dist. No.

01709

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 13yr5mth18dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Preller Last Preller				4. DATE OF DEATH Month Feb. Day 11 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1890	
9. AGE (In years last birthday) 69 yrs.		10. UNDER 1 YEAR Months 6 Days 11 Hours 11 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
13. FATHER'S NAME Andrew Preller				14. MOTHER'S MAIDEN NAME Mary A. Gaff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, terminal 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 12 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 30, 1960 to Feb. 11, 1960 , that I last saw the deceased alive on Feb. 11, 1960 , and that death occurred at 6:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward T. Schnoor				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2-11-60			
PHYSICIAN'S NAME (Type) Edward T. Schnoor, M.D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb. 15, 1960		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) BALTO. Md	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS CO 4905 York				ADDRESS 4905 York		24a. REC'D BY REGISTRAR FEB 15 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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1950 CERTIFICATE OF DEATH

DEATH CERTIFICATE



1950

Blank lines for text entry, including fields for name, date, and cause of death.

1950

1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01710

1556

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dundalk</u> <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Res., 21 Admiral Blvd.</u>			d. STREET ADDRESS <u>21 Admiral Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Frank</u> First <u>Thomas</u> Middle <u>Ramsey</u> Last			4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1902</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Thomas Ramsey</u>			14. MOTHER'S MAIDEN NAME <u>Anna ???</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-8973</u>		17. INFORMANT <u>Mrs. Thelma Schuman</u> Address <u>6120 Shipview Way 24</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease</u> (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/25/60</u>	
EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-29-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Eastern Blvd. Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Duda</u>			ADDRESS <u>7922 Wise Ave. 22, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 29 '60</u>
			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 Robinson Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ringoldia Middle Ranson Last Ranson		4. DATE OF DEATH Month Feb. Day 16th. Year 19 60	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10th. 1910
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min. 49	IF UNDER 24 HRS. Hours 49 Min. 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Essix Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Skipmore Young		14. MOTHER'S MAIDEN NAME Annie Ransing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Rev. Shirley Ranson		Address 10 Robinson Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of Breast DUE TO Conditions, if any, which gave rise to immediate cause (b) 170 X stating the underlying cause lost. (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170 X			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE JACK C COLLINS		DATE SIGNED 2-16-60	
EXAMINER'S NAME (Type) JACK C COLLINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/60	
22c. NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		23b. ADDRESS 1000 Brantley Ave.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE 2-16-60	

1721 CERTIFICATE OF DEATH

Reg. Dist. No.

01712

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5619 North Ave.		d. STREET ADDRESS 5619 North Ave.	
3. NAME OF DECEASED (Type or print) First Harry Middle Ray Last Sr.		4. DATE OF DEATH Month Feb. Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Retired packer		10b. KIND OF BUSINESS OR INDUSTRY Commission House	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216 07 1521 A	
17. INFORMANT Mrs. Lizzie Ray		Address 5619 North Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO myocarditis (b) arteriosclerotic vascular disease DUE TO 93 (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 593		INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 15, 1960 to Feb 29, 1960 , that I last saw the deceased alive on Feb 29, 1960 , and that death occurred at 5 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Rugley		ADDRESS (Street, city or town, state) 1 W. OVERLEA AVE BALTO, 6 Md	
PHYSICIAN'S NAME (Type) DR. DIGLER		DATE SIGNED 3-1-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3/60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1722

CERTIFICATE OF DEATH

Reg. Dist. No.

01713

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Monkton		c. LENGTH OF STAY IN 1b 45 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARTHA WALSH REICHERT		4. DATE OF DEATH Month Feb Day 18 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Long Green, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Walsh		14. MOTHER'S MAIDEN NAME Mary Roach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Fredrick Reichert		Address Monkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-15 , 19 60 , to 2-18 , 19 60 , that I last saw the deceased alive on 2-17 , 19 60 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Herbert Mueller Jr. M.D.		ADDRESS (Street, city or town, state) YORK RD. PARKTON MD DATE SIGNED 2/18/60	
PHYSICIAN'S NAME (Type) C. Herbert Mueller Jr.		Parkton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/1960	
22c. NAME OF CEMETERY OR CREMATORY Good Will		22d. LOCATION (City, town, or county) (State) Rutledge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kurtz		ADDRESS Garrettsville Md.	
24a. REC'D BY REGISTRAR FEB 23 '60		24b. REGISTRAR'S SIGNATURE C. C. Kurtz	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1723 CERTIFICATE OF DEATH

Reg. Dist. No.

01714

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY V	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 4412 Belvue Ave.	
3. NAME OF DECEASED (Type or print) Sarah Ann Ringer		4. DATE OF DEATH Month 2 Day 10 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1873
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Geoghegan		14. MOTHER'S MAIDEN NAME Laura V. Salgee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Emily J. Snyder - 8436 Church Rd.		Address Riviera Beach, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decomensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertensive Cardio-Vascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 wks. 15 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-29, 1959 , to 2-10, 1960 , that I last saw the deceased alive on 2-10, 1960 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore, Md. DATE SIGNED 2-10-60			
ACTUAL SIGNATURE Wilmer K. Gallagher		PHYSICIAN'S NAME (Type) Wilmer K. Gallagher Baltimore, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/13/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. 17th		24a. REC'D BY REGISTRAR DATE FEB 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1724 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Mryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 6790 Baltimore Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milton Middle Orville Last Robey		4. DATE OF DEATH Month Feb. Day 17 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1890
9. AGE (In years lost birthday) 69		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Milton Robey		14. MOTHER'S MAIDEN NAME Mattie Clements	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cardiac failure (c) Arteriol. Cardiovasc. Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5 , 1960, to Feb. 17 , 1960, that I last saw the deceased alive on February 17 , 1960, and that death occurred at 6.25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 2/17/60	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/20/60	22c. NAME OF CEMETERY OR CREMATORY BUMPY CATH	22d. LOCATION (City, town, or county) (State) PENOMKEY Md
23. FUNERAL DIRECTOR'S SIGNATURE Harold Funeral Home		ADDRESS Waldorf Md.	
24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1730

1730

Milton Road - Martin Clement

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1725 CERTIFICATE OF DEATH

Reg. Dist. No.

01716

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 44 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rockwell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emilie Middle Rockstroh Last		4. DATE OF DEATH Month Feb. Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1885
9. AGE (In years lost birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Daniel Flugard	
14. MOTHER'S MAIDEN NAME Augusta Raduhn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		INFORMANT Address 28, Md. Albert Rockstroh Rockwell Ave. Catonsville -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Systemic Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH immediate	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/20, 1957 , to 2/22, 1960 , that I last saw the deceased alive on 2/12, 1960 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1047 Ingleside Ave (28) DATE SIGNED ACTUAL SIGNATURE Thos J Miller M.D. PHYSICIAN'S NAME (Type) MAX J. Miller M.D. Baltimore Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/25/1960	22c. NAME OF CEMETERY OR CREMATORY Salem Lutheran Cem.	22d. LOCATION (City, town, or county) (State) Catonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons		24a. REC'D BY REGISTRAR FEB 26 1960	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus

1898 CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Color		Marital Status	
John Doe		45		Male		White		Married	
Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St, Baltimore, Md		Teacher		Heart Disease		Jan 15, 1898		Home	
Physician		Burial Place		Burial Date		Burial Time		Burial Place	
Dr. J. Smith		St. Mary's Church		Jan 17, 1898		10:00 AM		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Undertaker		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1726

CERTIFICATE OF DEATH

01717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Nursing Home</u> <u>Smithwood and Summit Aves.</u>		d. STREET ADDRESS <u>203 E. Lafayette Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nannie</u> Middle <u>F.</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1883</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas W. Rose</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Tolley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Address <u>Mrs. Madeline Hashagen, 1221 Woodbourne Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Pulmonary Edema Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO <u>Congestive Heart Failure</u> (c) DUE TO <u>Acute & Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1958</u> to <u>2/17/60</u> , that I last saw the deceased alive on <u>2/17/60</u> and that death occurred at <u>4:30 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGraw M.D.</u>		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd</u> DATE SIGNED <u>2/18/60</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGraw M.D.</u>		<u>Catonsville, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-22-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u> ADDRESS <u>1217 St. Paul St.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	
<u>Baltimore</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. McGraw</u>	

STATE OF NEW YORK
CERTIFICATE OF DEATH

1138

1138

[Faint, mostly illegible text and markings on a death certificate form, including fields for name, date, and location.]

14
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6109 Windsor Mill Road					d. STREET ADDRESS 6109 Windsor Mill Road									
3. NAME OF DECEASED (Type or print) First OSIE Middle D. Last RUTTER					4. DATE OF DEATH Month February Day 25 Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1896		9. AGE (In years last birthday) #63 IF UNDER 1 YEAR: Months 6 Days 3 IF UNDER 24 HRS.: Hours 0 Min. 0						
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Davis West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Arthur J. Ervin					14. MOTHER'S MAIDEN NAME Viola G. Hill									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Edward L. Rutter 6109 Windsor Mill Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, acute 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)										INTERVAL BETWEEN ONSET AND DEATH				
2De. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.					M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 2/26/60				
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.					Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 2-29-60		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery			22d. LOCATION (City, town, or country) (State) Woodlawn, Maryland						
23. FUNERAL DIRECTOR Ellsworth Armacost, Baltimore, Md.					24a. REC'D BY REGISTRAR FEB 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw							

01718

11-118

RECEIVED
JAN 11 1953
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

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1728 CERTIFICATE OF DEATH

Reg. Dist. No.

01719

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2800 CUB HILL</u>				c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2800 CUB HILL ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNSTENA K RYE</u>				4. DATE OF DEATH Month Day Year <u>FEB 20 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 3, 1875</u>	
9. AGE (In years last birthday) yrs. <u>84</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHRISTIAN C RYE</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA DUMHARDT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT Address <u>LEONARD RYE 2800 CUB HILL ROAD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>congestive failure</u> DUE TO (c) <u>genl arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5-10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Mar 1, 1950</u> to <u>2/20/1960</u> that I last saw the deceased alive on <u>2/19</u> , 19 <u>60</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3009 EVERGREEN AVE.</u> ACTUAL SIGNATURE <u>Donald W. Mintzer</u> M.D. PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u> <u>BALTIMORE MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/20/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jessie Funeral Home 7401 Belair Rd #6</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF ANALYSIS

1753

Sample No. 1753

Analysis of 1753

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1729 CERTIFICATE OF DEATH

01720

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Front Royal 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS 83x-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUIS SAGER First Middle Last				4. DATE OF DEATH Feb. 14 Month Day Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rose Lazarus Address 3706 Liberty Heights Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decomposition 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ch. Arteriosclerosis + Cerebral arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 wks. 103rd(?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-26-1960 to 2-14-1960 , that (I) was lost saw the deceased alive on 2-14-1960 , and that death occurred on 2-14-1960 at 1:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Wilmer K. Gallagher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/15/60	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D.				22d. ADDRESS 6209 Frederick Ave. Balt. 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/60		23c. NAME OF CEMETERY OR CREMATORY Both Tfiloh		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kline ADDRESS 6010 Reist Rd. #15				25a. REC'D BY REGISTRAR FEB 17 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

26. *et al.*

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01721

1730 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1415 Linden Avenue 3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Presbyterian Home</u>			d. STREET ADDRESS <u>Baltimore</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Clara May Sanders</u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>19 60</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1873</u>		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Thomas Edward Sanders</u>			14. MOTHER'S MAIDEN NAME <u>Mary Susan Aueos</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>T.E. Elliott Presbyterian Home</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary occlusion</u> (c) <u>Coronary heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:34</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Donald L. Somerville</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Donald L. Somerville</u>		22d. ADDRESS <u>25 W. Pennsylvania Ave., Towson</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church</u>	
23d. LOCATION (City, town, or county) (State) <u>Madonna, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitthell & Sons, Inc.</u>		ADDRESS <u>1900 Eutaw Place</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

CERTIFICATE OF DEATH

1930

1. Name of deceased: *John J. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1930*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *Dr. J. H. Jones*

8. Signature of registrar: *John Doe*

9. Date of registration: *Jan 16 1930*

10. Place of registration: *New York City*

© 1930 J. H. Jones

2000-001-001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1731

CERTIFICATE OF DEATH

Reg. Dist. No.

01722

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b X Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8728 Church Lane		d. STREET ADDRESS 8728 Church Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First H. Wilhelm Middle Sands Last Sands		4. DATE OF DEATH Month February Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1900
9. AGE (In years lost birthday) yrs. 59		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Howard Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Sands		14. MOTHER'S MAIDEN NAME Mary Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-8765	
17. INFORMANT Dorothy Sands - 8728 Church Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 15 min.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 29, 1960 to Feb. 23, 1960 , that I last saw the deceased alive on Feb. 22, 1960 , and that death occurred at 8:45 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. Martin		ADDRESS (Street, city or town, state) Randallstown Md DATE SIGNED	
PHYSICIAN'S NAME (Type) William E. Martin		RANDALLSTOWN Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-27-60	22c. NAME OF CEMETERY OR CREMATORY West Liberty	22d. LOCATION (City, town, or county) (State) Howard Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Lane		ADDRESS 802 Madison Avenue Baltimore, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

CERTIFICATE OF DEATH

1931

<p>NAME OF DECEASED [Illegible Name]</p>		<p>AGE [Illegible Age]</p>	
<p>SEX [Illegible Sex]</p>		<p>RACE [Illegible Race]</p>	
<p>DATE OF BIRTH [Illegible Date]</p>		<p>DATE OF DEATH [Illegible Date]</p>	
<p>PLACE OF BIRTH [Illegible Place]</p>		<p>PLACE OF DEATH [Illegible Place]</p>	
<p>RESIDENCE [Illegible Address]</p>		<p>CAUSE OF DEATH [Illegible Cause]</p>	
<p>DIAGNOSIS [Illegible Diagnosis]</p>		<p>PERMANENCE OF DEATH [Illegible Permanence]</p>	
<p>SIGNATURE OF PHYSICIAN [Illegible Signature]</p>		<p>SIGNATURE OF REGISTRAR [Illegible Signature]</p>	
<p>DATE [Illegible Date]</p>		<p>TIME [Illegible Time]</p>	

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1932

DATE OF DEATH

1932

PLACE OF DEATH

1932

CAUSE OF DEATH

1932

AGE AT DEATH

1932

SEX

1932

EDUCATION

1932

OCCUPATION

1932

RELIGION

1932

DATE OF BIRTH

1932

PLACE OF BIRTH

1932

DATE OF MARRIAGE

1932

PLACE OF MARRIAGE

1932

DATE OF INTERMENT

1932

PLACE OF INTERMENT

1932

DATE OF BURIAL

1932

PLACE OF BURIAL

1932

DATE OF CREMATION

1932

PLACE OF CREMATION

1932

01724

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

Abstract

1111

1734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19 Walnut Ave</u>		d. STREET ADDRESS <u>19 Walnut Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christopher Schmidt</u>		4. DATE OF DEATH Month Day Year <u>Feb 5 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Statistician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>August Schmidt</u>		14. MOTHER'S MAIDEN NAME <u>Anna ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>705-05-2623</u>	
17. INFORMANT <u>Hamilton A. Schmidt</u>		Address <u>19 Walnut Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480X Broncho-pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Grippe</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>Feb 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb. 4</u> , 19 <u>60</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R Donald Jandorf</u> M.D. <u>1077 Hayford Rd.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2-5-60</u>	
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>		<u>Balto Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Ave Rd Balto. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Bros.</u> ADDRESS <u>7110 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

1. Name of Deceased: *John A. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *Jan 15, 1900*

5. Place of Birth: *Baltimore, Md.*

6. Date of Death: *Dec 10, 1945*

7. Time of Death: *10:30 AM*

8. Cause of Death: *Myocardial Infarction*

9. Place of Death: *Home*

10. Signature of Physician: *Dr. J. H. Jones*

11. Signature of Registrar: *W. H. Smith*

12. Signature of Coroner: *John A. Smith*

13. Signature of Burial Officer: *John A. Smith*

14. Signature of Undertaker: *John A. Smith*

15. Signature of Minister: *John A. Smith*

16. Signature of Cemetery: *John A. Smith*

17. Signature of Burial: *John A. Smith*

18. Signature of Burial: *John A. Smith*

19. Signature of Burial: *John A. Smith*

20. Signature of Burial: *John A. Smith*

1735

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>6yr 4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>1400 W. Lexington St.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Albert</u> Last <u>Schmidt</u>				4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-36</u>	9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u> <u>Thusco Schmidt</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u> <u>Bertha Mann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKN OWN</u>		16. SOCIAL SECURITY NO. <u>218-10-2493A</u>		INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vasc. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general, severe</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>11/24</u> , 19 <u>59</u> , to <u>2/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/20</u> , 19 <u>60</u> , and that death occurred at <u>2:15 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp.</u> DATE SIGNED <u>2/20/60</u>			
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>				<u>Catonsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 25 '60.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Franz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

MASSACHUSETTS DEPARTMENT OF HEALTH - BACON NO. 18

NAME OF DECEASED: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF BIRTH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

DIAGNOSIS: _____

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN: _____

SIGNATURE OF REGISTRAR: _____

OFFICIAL USE ONLY

1736 CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore ✓✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 32yrs10mos7days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 5405 Summerfield Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUGUST Middle (NMI) Last SCHMITZ		4. DATE OF DEATH Month February Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal worker		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AUGUST SCHMITZ		14. MOTHER'S MAIDEN NAME LAURA HAUMANN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Elizabeth Schmitz, 5405 Summerfield Ave., (wife) Baltimore 6, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized moderate		INTERVAL BETWEEN ONSET AND DEATH 7-10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 21, 1927 to February 28, 1960 , and that death occurred at 2:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 2-29-60			
ACTUAL SIGNATURE J. L. Garey		PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3/1/1960	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR MAR 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

Figure 1. Schematic diagram of the experimental setup.

James Jones

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(I.12)

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FLAVIAN ARBAT

100-443887-100 (100)



50%

1997-1998

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07-1(9)-2 • Volume 1, Page 1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 DUTTON AVE.				d. STREET ADDRESS 1 16 DUTTON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle SCHOTT Last SCHOTT				4. DATE OF DEATH Month FEB. Day 8 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 2, 1878		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN-RET.		10b. KIND OF BUSINESS OR INDUSTRY MEAT CO.		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SCHOTT				14. MOTHER'S MAIDEN NAME JOHANNA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Hubert Krebs - 16 Dutton Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Degenerative Heart Disease 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ② Bronchiectasis chronic DUE TO (c) ③ Bronchitis Acute & chronic ④ Emphysema Pulmonary chronic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ⑤ Cholangitis chronic							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 56 , to 2/8/60 , that I last saw the deceased alive on 2/6/60 and that death occurred at 600A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. Mc Grath		M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md		DATE SIGNED 2/8/60	
PHYSICIAN'S NAME (Type) W. E. Mc Grath							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-8-60		22c. NAME OF CEMETERY OR CREMATORY Brookside Catholic Cem.		22d. LOCATION (City, town, or county) (State) Brookside, Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home - Catonsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 9 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

1933

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1888		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 15 1910		NEW YORK		NEW YORK		NEW YORK		JAN 15 1933		NEW YORK		NEW YORK	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		DATE OF ONSET		DATE OF TERMINATION		DATE OF INTERMENT	
HEART DISEASE		CORONARY ARTERY DISEASE		ANGINA PECTORIS		HYPERTENSION		DIABETES		JAN 15 1933		JAN 15 1933		JAN 15 1933	
PLACE OF INTERMENT		CITY		COUNTRY		DATE OF INTERMENT		DATE OF BURIAL		DATE OF CREMATION		DATE OF EXHUMATION		DATE OF REINTERMENT	
ST. JOHN'S CATHEDRAL		NEW YORK		NEW YORK		JAN 15 1933		JAN 15 1933							
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAMES J. JONES		JAN 15 1933		NEW YORK		NEW YORK		NEW YORK		JAN 15 1933		JAN 15 1933		JAN 15 1933	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01729

1738

Item 12 Film G258 3-7-60 et

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1435 Taylor Avenue</u>		d. STREET ADDRESS <u>1435 Taylor Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Warner</u> First Middle Last		4. DATE OF DEATH <u>February 25th</u> 19 <u>60</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Sweden</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>219-05-0822</u>	
17. INFORMANT <u>Mr. Warren Schudell</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u> DATE <u>MAR 1 '60</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1739

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01730

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Long Green Pike		d. STREET ADDRESS Long Green Pike	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY SCHWEIKART		4. DATE OF DEATH Month February Day 14 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1885
9. AGE (In years lost birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-retired	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Martin Shhweikart		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hours 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to Feb-14 , 19 60 , that (I) (we) last saw the deceased alive on Feb-13 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Walter M. Hammatt		22b. DATE SIGNED Feb-16-60	
22c. PHYSICIAN'S NAME (Type) Walter M. Hammatt		22d. ADDRESS Baldwin	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 17, 1960	
23c. NAME OF CEMETERY OR CREMATORY Fork Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Fork, Balto. Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. RECEIVED BY REGISTRAR FEB 16 1960	
25b. REGISTRAR'S SIGNATURE Carroll S. Harris			

1732

CERTIFICATE OF DEATH

Name of Deceased		John Smith	
Sex		Male	
Age		65	
Date of Birth		Jan 15, 1900	
Place of Birth		New York, N.Y.	
Cause of Death		Heart Disease	
Date of Death		Feb 10, 1965	
Place of Death		New York, N.Y.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

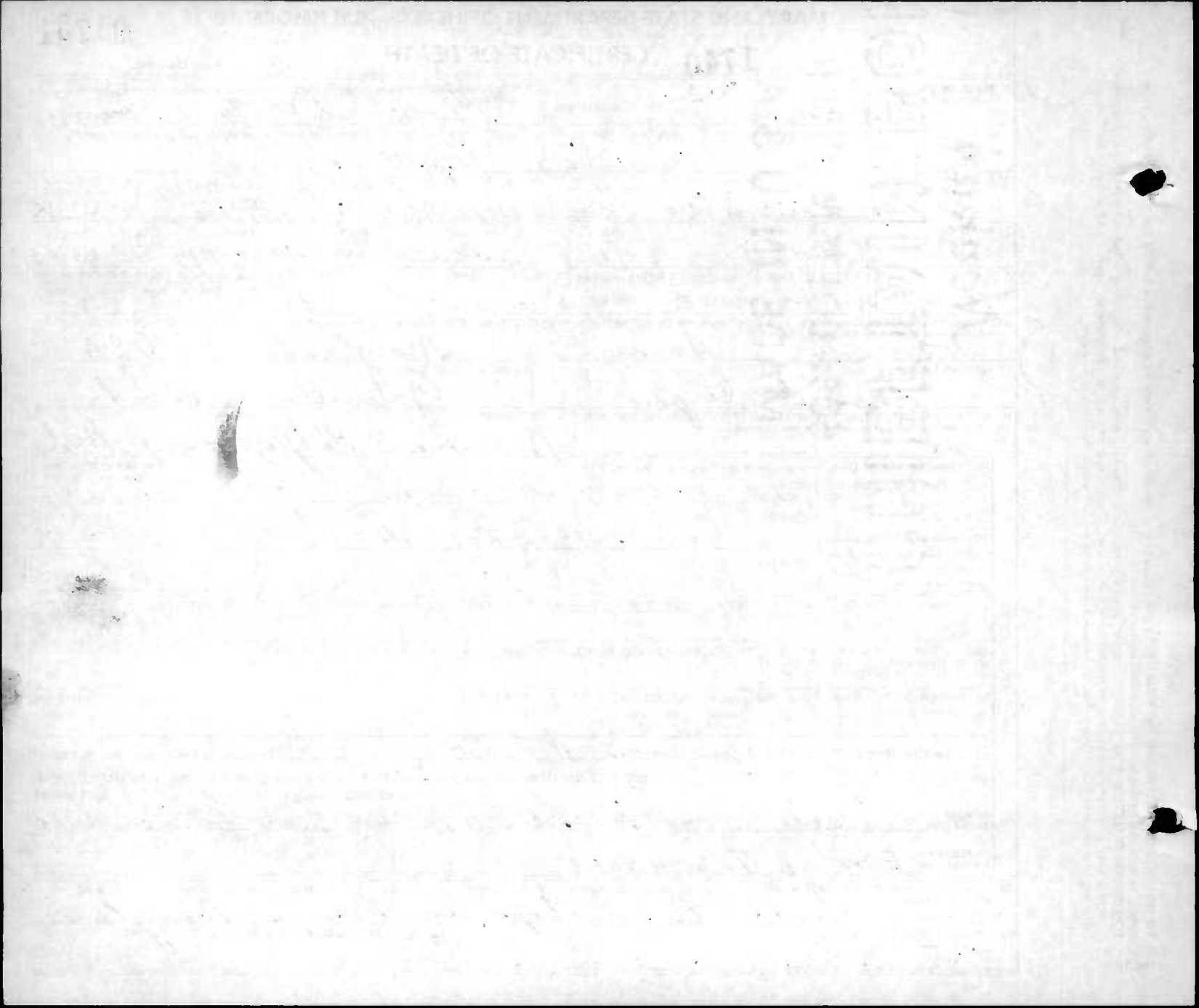
John Smith, born Jan 15, 1900, died Feb 10, 1965, at New York, N.Y.

1740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catersville</u>				c. LENGTH OF STAY IN 1b <u>10m 13 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>W.</u> Last <u>Shea</u>				4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-71</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Klugan</u>				14. MOTHER'S MAIDEN NAME <u>Gabriella Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>		INFORMANT Address <u>Mrs. S. Phelps, Bonnie, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Febr. 11</u> , 19 <u>60</u> , to <u></u> , 19 <u></u> , that I last saw the deceased alive on <u></u> , 19 <u></u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward T. Schnoor</u>				ADDRESS (Street, city or town, state) <u>3718 Belvedere Road Baltimore 18 Md</u> DATE SIGNED <u>2-11-60</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD T. SCHNOOR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Perkins Chapel Am.</u>		22d. LOCATION (City, town, or county) (State) <u>Bonnie Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dwight Randolph</u>				ADDRESS <u>Bonnie Md</u>		24a. REC'D BY REGISTRAR <u>FEB 16 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Carlton E. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1741
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01732

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE	c. LENGTH OF STAY IN 1b 7 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 708 WEST 34TH ST.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JENNIE Middle E Last SHEFFER		4. DATE OF DEATH Month FEB Day 28 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1884
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME JOSEPH LITCHFIELD	
14. MOTHER'S MAIDEN NAME MARGARET SAKERS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiac 260X DUE TO Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Diabetes (c) 7 years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-23, 1959 to 2-26, 1960 , that (I) (we) last saw the deceased alive on 2-26, 1960 , and that death occurred at 7:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 2/28/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial March 2-1960		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Wood Ridge		23d. LOCATION (City, town, or county) (State) Likesville Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Burgess Funeral Home Harold F. Burgess		25a. REC'D BY REGISTRAR DATE MAR 1 '60	
25b. REGISTRAR'S SIGNATURE Curtis S. Kenna			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1923

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1742 CERTIFICATE OF DEATH

Reg. Dist. No.

01733

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson BALTIMORE 3401-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armacost Nursing Home</u>				d. STREET ADDRESS <u>6077 HARFORD Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Franklin</u> Last <u>Shirey</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>3</u> Year <u>19 60</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GARAGE</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William David Shirey</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Good</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs ARTHUR D EIERMAN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure.</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis of Liver.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Sept 8</u> , 19 <u>59</u> , to <u>Feb 3rd</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 3rd</u> , 19 <u>60</u> , and that death occurred at <u>Quincy</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andugan</u> M.D.				ADDRESS (Street, city or town, state) <u>15 E. Biddle St Baltimore 2</u> DATE SIGNED <u>2/3/60</u>			
PHYSICIAN'S NAME (Type) <u>F.M. DUGAN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

MEDICAL CERTIFICATION

174 CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson, Maryland</u>		LENGTH OF STAY (in this place) <u>6 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Springs</u> 1556-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>1014 Woodside Park,</u>			
3. NAME OF DECEASED (Type or Print) <u>ROBERTS, Mr. Curtis L. Sowers</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 5 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 14, 1896</u>		9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Defense</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Benjamin Sowers</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Koutz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1002X IMMEDIATE CAUSE (A) <u>Pulmonary tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pericarditis</u>						1 month	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/22/1959, to 2/5/1960, that I last saw the deceased alive on 2/5/1960, and that death occurred at 10:45 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/8/60</u>		NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. REC'D BY REGISTRAR <u>FEB 9 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

See Dir. 100

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. TIME OF DEATH

10. CAUSE OF DEATH

11. MEDICAL ATTENDANT

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF DECEASED

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESSES

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESSES

24. SIGNATURE OF DECEASED

25. SIGNATURE OF WITNESSES

26. SIGNATURE OF DECEASED

27. SIGNATURE OF WITNESSES

28. SIGNATURE OF DECEASED

29. SIGNATURE OF WITNESSES

30. SIGNATURE OF DECEASED

31. SIGNATURE OF WITNESSES

32. SIGNATURE OF DECEASED

33. SIGNATURE OF WITNESSES

34. SIGNATURE OF DECEASED

35. SIGNATURE OF WITNESSES

36. SIGNATURE OF DECEASED

37. SIGNATURE OF WITNESSES

38. SIGNATURE OF DECEASED

39. SIGNATURE OF WITNESSES

40. SIGNATURE OF DECEASED

41. SIGNATURE OF WITNESSES

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TO OBTAIN A COPY OF THIS FORM, APPLY TO THE BALTIMORE HEALTH DEPARTMENT, 100 N. CALVERT ST., BALTIMORE, MD. 21201

TO OBTAIN A COPY OF THIS FORM, APPLY TO THE BALTIMORE HEALTH DEPARTMENT, 100 N. CALVERT ST., BALTIMORE, MD. 21201

TO OBTAIN A COPY OF THIS FORM, APPLY TO THE BALTIMORE HEALTH DEPARTMENT, 100 N. CALVERT ST., BALTIMORE, MD. 21201

142131001072

Reg. Dist. No.

MEDICAL CERTIFICATION

VS. A15ME
SM 2/57

1748
 DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

01737

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8634 Quentin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARETTA Middle STAINES Last		4. DATE OF DEATH Month February Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Malcolm A. Fishpaw		14. MOTHER'S MAIDEN NAME Margaret C. Parks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Christian Staines, 8634 Quentin Ave., Towson 4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Duodenal ulcer, c obstruction & perforation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Disease Angina pectoris DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1957 to Feb 15, 1960 , that (I) (we) last saw the deceased alive on 2/13 19 60 and that death occurred at 10 A M , from the causes and on the date stated above.			
22a. SIGNATURE Donald W. Mintzer PHYSICIAN'S NAME (Type)		22b. DATE Feb 17, 1960 SIGNED	
22c. ADDRESS 3009 EVERGREEN AVE BALTO 14 MD		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 18, 1960	
23c. NAME OF CEMETERY OR CREMATORY Sater's Baptist Cemetery		23d. LOCATION (City, town, or county) (State) Lutherville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. RECEIVED BY REGISTRAR FEB 23 60 DATE	
25b. REGISTRAR'S SIGNATURE William S. Smith			

10-10-10

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1745

Married

Married

Married

Town of

Town of

8000 Madison Avenue

8000 Madison Avenue

10-10-10

Married

Married

Married

June 20, 1905

White

Married

Married

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1747

CERTIFICATE OF DEATH

01738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b 54 ESSEX			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 Eastern Blvd. (21)				d. STREET ADDRESS 127 Eastern Blvd. (21)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First STEVE Middle STANLEY Last				4. DATE OF DEATH Month FEB. Day 1 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1889	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 7 Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Stock Dealer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lincoln, Neb.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charlie Stanley				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Emma Stanley		Address 127 Eastern Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis H.D. hypertension 28 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9-25, 1957 to JANUARY 21, 1960 that I last saw the deceased alive on JANUARY 21, 1960 and that death occurred at 11 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Wexler		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 2502 Eutaw Place-Balto. 17, Md. 2/4/60					
PHYSICIAN'S NAME (Type) Jack Wexler, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 2-6-60		22c. NAME OF CEMETERY OR CREMATORY Moreland's Memorial		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connelly				ADDRESS 418 Eastern Blvd.		24a. REC'D BY REGISTRAR DATE FEB 8 '60	
				24b. REGISTRAR'S SIGNATURE William S. Travis			

CERTIFICATE OF DEATH

9-12 27 JANUARY 1960

JANUARY 21 1960

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1748 CERTIFICATE OF DEATH

01739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NURSING HOME</u>		d. STREET ADDRESS <u>2208 ASHTON</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H.</u> Last <u>STRICKER</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14, 1978</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WESTERN UNION</u>	11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>ELI STRICKER</u>	
14. MOTHER'S MAIDEN NAME <u>CLARA DAY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-10-1149</u>		17. INFORMANT <u>MRS. GEO. W. FOWLER</u> Address <u>2208 ASHTON ST. BALTO. 23, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cataracts Bilat postoperative Right.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1/29/60</u>	20f. (City or town) <u>2/7/60</u> (County) (State)
21. I certify that I attended the deceased from <u>1/29/60</u> to <u>2/7/60</u> , that I last saw the deceased alive on <u>1/29/60</u> , and that death occurred at <u>10:20 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGrath</u> M.D.		ADDRESS (Street, city or town, state) <u>1303 Frederick Rd. Catonsville 28md</u> DATE SIGNED <u>2/9/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/11/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Truman School</u> ADDRESS <u>3512 Frederick Ave. (29)</u>		24a. REC'D BY REGISTRAR <u>FEB 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01740

CERTIFICATE OF DEATH

1749

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTO. CO</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ESSEX</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>1021 MIDDLESEX ROAD.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>MARY</u> (Middle) <u>REIORDAN</u> (Last) <u>SAITS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 17 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>OCT 12 1890</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BARTHALEMEW REIORDAN</u>				14. MOTHER'S MAIDEN NAME <u>? ? ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>403-05-22910</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
002X IMMEDIATE CAUSE (A) <u>PULMONARY TUBERCULOSIS</u>						<u>10 YEARS</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIO-SCLEROTIC CARDIO VASCULAR Dis.</u>						<u>uncertain</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>60</u> , to <u>2/17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>60</u> , and that death occurred at <u>10:10 A</u> .M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
		<u>Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-20-60</u>		NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Garden</u>		LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex 21, Md.</u>	

CERTIFICATE OF DEATH

1728

Reg. Off. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

13. SIGNATURE OF BURIAL

14. SIGNATURE OF INTERMENT

15. SIGNATURE OF CREMATION

16. SIGNATURE OF OTHER

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MASSACHUSETTS

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE COMMONWEALTH OF MASSACHUSETTS. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BOSTON, AND IS TO BE PRODUCED TO ANY PERSON WHO REQUESTS IT. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

1 1760 Film G257 2-29-60 et MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE, 1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>30 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>STEVENS CARE HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>C.</u> Last <u>SWEET</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 26, 1868</u>	
9. AGE (In years lost birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Franklin Sweet</u>				Address <u>702 W. Hamburg St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Kyphoscoliosis, severe</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/11</u> , 19 <u>60</u> , to <u>2/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/17</u> , 19 <u>60</u> , and that death occurred at <u>10:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Nolan</u>				ADDRESS (Street, city or town, state) <u>1 Meadow Hill Ave</u>			
PHYSICIAN'S NAME (Type) <u>JAMES J. NOLAN</u>				DATE <u>2/19/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/22/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>				22d. LOCATION (City, town, or county) (State) <u>ELKridge, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab Funeral Home</u> <u>Francis W. Moller 2101 Frederick Ave</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove upon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1751

CERTIFICATE OF DEATH

01742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. CO. 206 Potomac Ave. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE				c. LENGTH OF STAY IN 1b 20 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 POTOMAC AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maida Middle E. Last Tabeling				4. DATE OF DEATH Month Feb. Day 22 Year 19 60			
5. SEX FEM.		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 29, 1884	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO - MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CONSTANTINE EBERDT				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MAURICE EBERDT		Address 206 POTOMAC AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO Coronary (c) Generalized/arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 20 years 1 1/2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pernicious Anemia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 18 , 19 60 , to Feb. 22 , 19 60 , that I last saw the deceased alive on February 22 , 19 60 , and that death occurred at 1:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9660 Belair Road DATE SIGNED Theodore E. Evans							
ACTUAL SIGNATURE Theodore E. Evans M.D.							
PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D.				Baltimore 6, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-25-60		22c. NAME OF CEMETERY OR CREMATORY OAKLAWN		22d. LOCATION (City, town, or county) (State) BALTO COUNTY	
23. FUNERAL DIRECTOR'S SIGNATURE C.F. Hoffmann ADDRESS 3218 Hudson St.				24a. REC'D BY REGISTRAR DATE 23 60		24b. REGISTRAR'S SIGNATURE William L. Kraus	

MEDICAL CERTIFICATION

TO HOST: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1751

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH April 15, 1941		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:30 AM		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Coronary Artery Disease		10. PERMANENT DAMAGE None	
11. SIGNATURE OF PHYSICIAN J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris, J. H. Harris	
13. SIGNATURE OF REGISTRAR J. H. Harris		14. SIGNATURE OF CLERK J. H. Harris	

1752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Olive Middle Jane Last Taylor		4. DATE OF DEATH Month Feb. Day 15, Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1889
		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME John H. Wade	14. MOTHER'S MAIDEN NAME Margaret E. Niedert
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	INFORMANT Mrs. Henry Tregoe - Old Court Rd.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor. dis. failure, arteriosclerosis, 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis, chronic DUE TO (c) pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1959 to 15 Jan 60
---	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1954 , 19____, to 15 Jan , 1960, that I last saw the deceased alive on 15 Jan , 1960, and that death occurred at 1:00 P.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Harold E. Hall M.D.	ADDRESS (Street, city or town, state) A. A. Co., Md. DATE SIGNED 15 Jan 60
PHYSICIAN'S NAME (Type)	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/18/60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) A. A. Co., Md.
--	-------------------------------------	--	--

23. FUNERAL DIRECTOR'S SIGNATURE Mr. J. Lieberman & Sons - Balto 17	ADDRESS Md	24a. REC'D BY REGISTRAR DATE FEB 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1752

DEPARTMENT OF HEALTH

MASSACHUSETTS

Name of Deceased: _____
 Sex: _____
 Date of Birth: _____
 Date of Death: _____
 Place of Birth: _____
 Usual Residence: _____
 Cause of Death: _____
 Physician: _____
 Burial Place: _____
 Registrar: _____
 Date: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>WIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>109 E. CHEASPEAKE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BESSIE F. THOMAS</u>		4. DATE OF DEATH <u>2/8/60</u> 19 <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9 1928</u>
9. AGE (In years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>FANNIE THOMAS</u>		Address <u>440 W. A. AVE. TOWSON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choked to death from Carbon Dioxide</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Caught in 2nd floor room in burning building</u>	
20c. TIME OF INJURY Month, Day, Year <u>10 2-8-60</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Towson Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/8/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/10/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Stutzman</u>		ADDRESS <u>1721 Mt. Calhoun Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 10 '60</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

03

2

3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 14
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

645

1754
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2m and 2days Baltimore 51		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 2919 Georgia Avenue-Balto.27	
3. NAME OF DECEASED (Type or print) First William Middle F. Last Timme		4. DATE OF DEATH Month February Day 11 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1899	9. AGE (In years last birthday) yrs. 60	10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) genl. manager		10b. KIND OF BUSINESS OR INDUSTRY Packing Austin Peanut Co.		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME unknown Louis Timme			
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown			
16. SOCIAL SECURITY NO. unknown		INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SPRING GROVE STATE HOSPITAL	
20f. (City or town) Balto.		(County) Md.		(State) Md.	
21. I certify that I attended the deceased from Dec. 9, 1959 to Feb. 11, 1960 that I last saw the deceased alive on Feb. 11, 1960 , and that death occurred at 7:20am , from the causes and on the date stated above.					
ACTUAL SIGNATURE Stella Wachser		DATE SIGNED 2-11-60			
PHYSICIAN'S NAME (Type) Stella Wachser, M. D.		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
22d. LOCATION (City, town, or county) Balto., Md.		(State) Md.		23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto.	
24a. REC'D BY REGISTRAR FEB 15 60		24b. REGISTRAR'S SIGNATURE Charles A. [illegible]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

DECEASED

DATE

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

SEX

PLACE OF BIRTH

AGE

DATE

PLACE

AGE

DATE

PLACE

DATE

AGE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1755 CERTIFICATE OF DEATH

01746

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

4235 DARLEIGH ROAD

(c) Hospital or institution:

5743 Edmondson Avenue
RIDGEWAY MANOR

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State M.D. (b) County

(c) City or town

Balto. Md

(If outside city or town limits, write RURAL and give town)

(d) Street No.

814 G. Rose St 3V014

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

3 (a) FULL NAME

ANDREW TOMICK (TOMICK)

3 (b) If veteran, name war

None

3 (c) Social Security Account

No.

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Timie Tomick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: 82 Years Months Days If less than one day
BIRTHDAY NOV 20 1879 hr. min.

9. Birthplace

Austria-Hungary
(Town, county, and state)

10. Usual Occupation

Stoker

11. Industry or business

Steam Ships

12. Name

Joseph Tomick

13. Birthplace

Austria-Hungary

14. Maiden Name

Unkown

15. Birthplace

Austria-Hungary

16 (a) Informant

James Tomick

(b) Address

814 G. Rose St

17 (a) Burial, cremation, or removal

Burial

(b) Date thereof

2-22-60

(month) (day) (year)

(c) Cemetery or crematory

Holy Redeemer

Location

Balto 6 Md

18 (a) Funeral director

Gr. Grachison

(b) Address

909 G. Rose St

19 (a) Date rec'd by registrar

2-22-60

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/19 1960, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1955, to 2/19 1960, and that I last saw him alive on 2/15 1960.

Immediate cause of death

Myocardial Infarction

Duration

Coronary Thrombosis

Multiple

Due to Cerebral Arteriosclerosis

Over 10 yrs

Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature William G. Cannon

Address 508 Balt. Nat. Pike Date signed 2/19/60

M. D.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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01747

CERTIFICATE OF DEATH

Reg. Dist. No.

1756

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1726 G. Doolittle Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Denis</i> Middle <i>K.</i> Last <i>Touhey</i>				4. DATE OF DEATH Month <i>February</i> Day <i>8.</i> Year <i>19 60</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/24/87</i>	
9. AGE (In years last birthday) <i>72</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Storekeeper</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Denis K. Touhey</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Lynch</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give year or dates of service) <i>WW I</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>Margaret Touhey 1726 G. Doolittle Road</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Cerebral Hemorrhage</i> DUE TO (b) <i>Hypertension-</i> DUE TO (c) <i>Coronary Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>7 yr.</i> <i>7 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb.</i> , 19 <i>53</i> , to <i>Feb. 8</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Feb. 8</i> , 19 <i>60</i> , and that death occurred at <i>5:15 P.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>David Schneider</i>				DATE SIGNED <i>1101 N. Milton Ave. Baltimore, Md.</i>			
PHYSICIAN'S NAME (Type) <i>David Schneider, M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/12/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i> ADDRESS <i>3000 E. Baltimore Street Balto. Md.</i>				24a. REC'D BY REGISTRAR DATE <i>FEB 12 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

01748

1. PLACE OF DEATH a. COUNTY <u>Baltimore,</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudbrook Park, Pikesville</u>		c. LENGTH OF STAY IN 1b <u>135 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>505 Sudbrook Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILLARD</u> Middle <u>TOLSON</u> Last <u>TRABAND</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28,</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1890</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traveling Auditor B&O RR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Traband</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Tolson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Emily C. Traband</u>		Address <u>505 Sudbrook Lane, Balt. 8, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>*****</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>*****</u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <u>Not</u> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>*****</u>		20f. (City or town) (County) (State) <u>*****</u>	
21. I certify that I attended the deceased from <u>1944</u> , to <u>February</u> , 1960, that I last saw the deceased alive on <u>28 February</u> , 1960, and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5101 Gwynn Oak Ave.</u> DATE SIGNED <u>2/29/60</u>			
ACTUAL SIGNATURE <u>Millard T. Traband</u>		M.D. <u>5101 Gwynn Oak Ave.</u> <u>2/29/60</u>	
PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr. M. D.</u>		<u>Baltimore, 7, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickner & Sons - Balt.</u>		ADDRESS <u>17</u>	
24a. REC'D BY REGISTRAR <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 11 1951

CERTIFICATE OF DEATH

1951

11-11-51

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

1 M 001 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death. 1758 01749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>none</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Towson</u>				c. LENGTH OF STAY IN 1b <u>7 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood Sanatorium Towson 4, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Tusznski</u> Last <u>Tusznski</u>				4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/18/01</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water Watcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>John Tusznski</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>219-14-0993</u>		17. INFORMANT <u>Personal History</u> Address <u>Hospital Records, Eudowood Sanatorium</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-10</u> , 19 <u>60</u> , to <u>2-17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>60</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Milton B. Kress</u> M.D.				Eudowood Sanatorium			
PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u>				Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozazowski</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

4359
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06712

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 15 X d. STREET ADDRESS / UNKNOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Found Druid Ridge Cemetery		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) UNKNOWN		4. DATE OF DEATH Month Day Year February 11 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs. Months Days		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME U N K N O W N		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795.5 Decomposing Body; No Anatomical Cause of Death. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUN 10 '60		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

9 ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

THE STATE
DEPARTMENT

1914

Office of the Secretary

WASHINGTON

February 1, 1914

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
Secretary

Charles E. Smith
Secretary

1914

1759 CERTIFICATE OF DEATH

Reg. Dist. No.

01750

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8805 Victory Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Louise</i> Last <i>Vogel</i>		4. DATE OF DEATH Month <i>2</i> Day <i>25</i> Year <i>19 60</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 7, 1892</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months <i>67</i> Days <i>67</i> Hours <i>67</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Stephen A. Douglas</i>		14. MOTHER'S MARDEN NAME <i>Anna B. Beam</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Mrs Alma Christopher same</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO <i>Cerebral Hemmorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO <i>10 yrs.</i> (c) <i>Arteriosclerosis, generalized, moderate</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 19 58</i> , to <i>Feb. 25, 19 60</i> that I lost saw the deceased alive on <i>Feb. 25, 60</i> , 19 <i>60</i> , and that death occurred at <i>10:45</i> AM, from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <i>Theodore E. Evans</i> M.D.		ADDRESS (Street, city or town, state) <i>9660 Belair Road</i>	
PHYSICIAN'S NAME (Type) <i>Theodore E. Evans, M.D.</i>		Baltimore 6, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>2/29/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24. REC'D BY REGISTRAR DATE <i>MAR 1 '60</i>	
ADDRESS <i>5305 Harford Rd</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Krassa</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY THE COURT: *WALTER J. CAMPBELL, JR., Clerk.*

1760

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN lb <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>2623 Frederick Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Estelle</u> Middle <u>MARIE</u> Last <u>Vogt</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22, 1887</u>		9. AGE (In years lost birthday) yrs. <u>72</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife (Bookkeeper)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT. STORE. DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel M. Vogt</u>				14. MOTHER'S MAIDEN NAME <u>Clara G. Mann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>216-03-3367</u>		INFORMANT <u>Records : SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterioscl. Cardio Vasc. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerosis, General, Heart</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 16, 1960</u> to <u>2/28</u> , 19 <u>60</u> that I last saw the deceased alive on <u>2/28</u> , 19 <u>60</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				M.D. <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>				<u>Catonsville 28, Maryland</u> <u>2/28/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab Funeral Home</u> <u>Francis or Miller 2101 Frederick Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

1980

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

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DATE OF BIRTH

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01752

1761

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2211 Druid Hill Avenue			
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last WALKER				4. DATE OF DEATH Month February Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 10, 1891	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		11. BIRTHPLACE (State or foreign country) Wilmot, Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Walker				14. MOTHER'S MAIDEN NAME Sarah Sanders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 216-09-6027		17. INFORMANT Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X (b) PULMONARY ABSCESSSES, MULTIPLE, BILATERAL (c) PULMONARY EDEMA AND PULMONARY EMPHYSEMA, MARKED, BILATERAL						INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1. Cardiac hypertrophy, slight. 2. Benign prostatic hypertrophy							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from Feb. 5 19 60 , to Feb. 8 19 60 , that W (we) last saw the deceased alive on 2/8/ 19 60 , and that death occurred at 2:50 AM , from the causes and on the date stated above.							
22a. SIGNATURE W. J. Pijanowski				22b. DATE SIGNED 2/9/60			
22c. PHYSICIAN'S NAME (Type) W. J. PIJANOWSKI, M. D.				22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/12/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR FEB 15 '60		25b. REGISTRAR'S SIGNATURE Charles E. Hume	
ADDRESS 1808 N. Monroe St. Balto. 17 Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1761

John Walker
born 1891
died 1961
cause of death
heart failure
buried in
cemetery

John Walker
born 1891
died 1961
cause of death
heart failure
buried in
cemetery

John Walker
born 1891
died 1961
cause of death
heart failure
buried in
cemetery

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Ans. by phone (Mr. MacNabb) 4-7-60 et

1762

CERTIFICATE OF DEATH

03054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Wall Last Wall		4. DATE OF DEATH Month February Day 20 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 70? yrs.		10. IF UNDER 1 YEAR Months 70? Days 70? Hours 70? Min. 70?	11. IF UNDER 24 HRS. Months 70? Days 70? Hours 70? Min. 70?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 422-01-684	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 26, 1960 to Feb. 20, 1960 that I last saw the deceased alive on Feb. 20, 1960 , and that death occurred at 11:20 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED 2-22-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/60	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE MacNabb & Son Co		ADDRESS Catonsville	
24a. REC'D BY REGISTRAR APR 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1563

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

PRE-EXISTING DISEASES

PERSONAL HISTORY

PREVIOUS DEATHS

PREVIOUS ILLNESSES

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

1763 CERTIFICATE OF DEATH

REG. NO. 1763

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]

4. Race: [illegible]

5. Date of death: [illegible]

6. Place of death: [illegible]

7. Cause of death: [illegible]

8. Manner of death: [illegible]

9. Signature of physician: [illegible]

10. Signature of registrar: [illegible]

11. Signature of coroner: [illegible]

12. Signature of medical examiner: [illegible]

13. Signature of funeral director: [illegible]

14. Signature of undertaker: [illegible]

15. Signature of cemetery: [illegible]

16. Signature of burial society: [illegible]

17. Signature of religious society: [illegible]

18. Signature of family: [illegible]

19. Signature of witnesses: [illegible]

20. Signature of registrar: [illegible]

21. Signature of coroner: [illegible]

22. Signature of medical examiner: [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-10-60	22c. NAME OF CEMETERY OR CREMATORY Betheda Meth.Church Cem.	22d. LOCATION (City, town, or county) Gist, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.,		ADDRESS 1217 St. Paul Street	24a. REC'D BY REGISTRAR DATE FEB 9 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

VS A15 (4)
15M 9/5B

CERTIFICATE OF DEATH

1900

1

23

1901

1559 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 238 Patapsco Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARROLL Middle C. Last WARD		4. DATE OF DEATH Month Feb. Day 14 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant		10b. KIND OF BUSINESS OR INDUSTRY Merchants Club	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Ward		14. MOTHER'S MAIDEN NAME Margaret Fitchette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-05-0439	
17. INFORMANT Mrs. Ella H. Ward - 238 Patapsco Ave. #22		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO (c) Bilateral hernia & senility		INTERVAL BETWEEN ONSET AND DEATH 4 years 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-6 , 19 55 , to 2-14 , 19 60 , that I last saw the deceased alive on 2-14 , 19 60 , and that death occurred at 10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene F. Newy		ADDRESS (Street, city or town, state) 7001 Morrison Ave. Md.	
PHYSICIAN'S NAME (Type) Eugene F. Newy M.D.		DATE SIGNED 2-14-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/60	
22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Lickner & Son - Balto		24a. REC'D BY REGISTRAR DATE FEB 17 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1955

File No.

DECEASED
Name of deceased

Sex

Age at death

Place of birth

Usual residence

Occupation

Date of death

Time of death

Place of death

Cause of death

Immediate cause

Underlying cause

Contributing cause

Manner of death

Signature of physician

Signature of coroner

Signature of registrar

Signature of witness

Signature of family

Signature of neighbor

Signature of clergyman

Signature of funeral director

Signature of undertaker

Signature of cemetery

Signature of burial place

Signature of interment

Signature of cremation

Signature of disposition

Signature of final disposition

Signature of record

Signature of filing

Signature of distribution

Signature of return

Signature of completion

Signature of closure

Signature of final record

Signature of final disposition

Signature of final record

Signature of final disposition

Signature of final record

Signature of final disposition

Signature of final record

Signature of final disposition

Signature of final record

Signature of final disposition

Signature of final record

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01756

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b in transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Painter Mill Road		d. STREET ADDRESS Finksburg R.D.1	
3. NAME OF DECEASED (Type or print) First Patricia Middle Dianne Last Webb		4. DATE OF DEATH Month Feb. Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1953
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 6 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School girl		10b. KIND OF BUSINESS OR INDUSTRY Elkton, Kentucky	
11. BIRTHPLACE (State or foreign country) Elkton, Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Burnett A. Webb		14. MOTHER'S MAIDEN NAME Mary Glenn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Burnett A. Webb		Address R.F.D.1 Finksburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture of skull DUE TO 822X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 20 min.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto overturned & crashed into utility pole	
20c. TIME OF INJURY Month, Day, Year Hour 1:30 p.m. 2-21-60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Painters Mill Rd., Owings Mills, Balto., Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		22d. LOCATION (City, town, or county) (State) Finksburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Luther Haight, Sykesville, Md.		24a. REC'D BY REGISTRAR DATE FEB 29 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
 TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
 15M 9/59

1765
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

01757

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5543 EDMONDSON AVE</u>		c. LENGTH OF STAY IN 1b <u>18 MONTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAMBERSBURG 75X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIGGEWAY MANOR NURSING HOME</u>				d. STREET ADDRESS <u>308 GLEN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>EDWIN</u> Last <u>WEBER</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/20/1875</u>		9. AGE (In years lost birthday) yrs. <u>84</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL PRINCIPAL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL PRINCIPAL</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEO. WEBER</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS ANN WEBER - 3415 OFFUTTA</u> Address <u>RANDOLPH TOWNSHIP</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>" " 18 MONTH AGO.</u> (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MINUTE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/12/57</u> to <u>7/2/60</u> that (I) (we) last saw the deceased alive on <u>1/19/60</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edwin L. Pierpont</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/2/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY RD, BALTO. 7, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Burial 2-5-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Morningside</u>		23d. LOCATION (City, town, or county) (State) <u>Real Beach, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 8 60</u>		25b. REGISTRAR'S SIGNATURE <u>James A. Hanna</u>	

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MANHATTAN DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1961

CHIEF OF BUREAU

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1768
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01758

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Ring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Ring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1225 Kenric k Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Georgianna Middle Weinreich Last		4. DATE OF DEATH Month Feb Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15 1917
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William T. Whiteley		14. MOTHER'S MAIDEN NAME Mary Kirby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Weinreich		Address 2314 Gross Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastases 170X DUE TO (b) Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 1 mo. 3 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1959 to Feb 7 1960 , that (I) (we) last saw the deceased alive on Feb 7 1960 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Louis Semenov		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LOUIS SEMENOFF		22d. ADDRESS 2108 CREMS RD, BALTO 20, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF Feb 10/60	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Co	
24. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home		25a. REC'D BY REGISTRAR FEB 10 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Scene -- Rt. 40, east of Middle River Rd.		d. STREET ADDRESS 804 LANNERTON RD.	
3. NAME OF DECEASED (Type or print) CHARLES W. WHITE, SR.		4. DATE OF DEATH Month February Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BLUEFIELD, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL O WHITE		14. MOTHER'S MAIDEN NAME MARTHA SIMPSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. C. W. WHITE JR. (SAME AS ABOVE)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple blunt-force injuries, as follows: multiple rib fractures, fractured spine, laceration of aorta, nearly complete transection of both lower legs, plus multiple head injuries Conditions, if any, which gave rise to immediate cause (b) multiple head injuries (a), stating the underlying cause last. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by auto	
20c. TIME OF INJURY Hour 7:15 p.m. Month, Day, Year 2/9 1960	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	20f. (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		DATE SIGNED 2/10/60	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-12-60	
22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL		22d. LOCATION (City, town, or country) (State) BALTO. MD.	
23. FUNERAL DIRECTOR John B. Connelly		24a. REC'D BY REGISTRAR FEB 17 '60	
ADDRESS +18 Eastern Blvd. (31)		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

VS. A15ME
5M 7/59

RECEIVED
JAN 10 1967
U.S. DEPARTMENT OF HEALTH
MEDICAL EXAMINER
BALTIMORE

1567
BALTIMORE

Room -- 111. No. 10, east of Middle River St.
WHITE, C.

1567
BALTIMORE

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BALTIMORE

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BALTIMORE

1768
CERTIFICATE OF DEATH

01760

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. LENGTH OF STAY IN 1b 54 Middle River			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 446 Whitethorn Way				d. STREET ADDRESS 446 Whitethorn Way			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle C. Last WILLIAMS (KRATZ)				4. DATE OF DEATH Month February Day 16 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME George L. Schreiner				14. MOTHER'S MAIDEN NAME Elizabeth Weber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Lillian Jenkins				Address 446 Whitethorn Way			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, Terminal 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the rectum with DUE TO (c) Metastasis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 9, 1960 to Feb. 16, 1960 , that I last saw the deceased alive on February 16, 1960 , and that death occurred at 1:20 P.M. from the causes and on the date stated above.							
ACTUAL PHYSICIAN'S NAME (Type) Miguel A. Castro Jr.				ADDRESS (Street, city or town, state) 805 FUSELAGE AVE			
DATE SIGNED 2/17/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Feb. 20, 1960		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.				24a. REC'D BY REGISTRAR DATE FEB 19 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1560 CERTIFICATE OF DEATH

Reg. Dist. No.

01761

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. d. STREET ADDRESS <u>75 Kershaw</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert W</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pier Supt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steamship Supt</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Joyce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr Bertha Wilson</u>		Address <u>75 Kershaw</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer, left upper lobe lung</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Accident - August - 1956 =</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1, 1956</u> to <u>Feb. 28, 1960</u> , that I last saw the deceased alive on <u>Feb. 22, 1960</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. B. Davis</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6800 Mornington Rd</u>	
PHYSICIAN'S NAME (Type) <u>M. B. Davis M.D.</u>		<u>Dundalk - 22 Feb 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William L. L. Home</u>		ADDRESS <u>2112 Dundalk Ave</u>	
24a. REC'D BY REGISTRAR <u>MAR 2 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. MANNER OF DEATH	
3. CAUSE OF DEATH		4. DATE OF DEATH	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. DATE OF BIRTH	
9. OCCUPATION		10. MARITAL STATUS	
11. EDUCATION		12. RELIGION	
13. PREVIOUS ILLNESS		14. PRESENT ILLNESS	
15. MEDICAL HISTORY		16. SURVIVAL OF DECEASED	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF WITNESSES	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF FUNERAL HOME	
21. SIGNATURE OF VENDOR		22. SIGNATURE OF REGISTRAR	
23. SIGNATURE OF CLERK		24. SIGNATURE OF OFFICIAL	
25. SIGNATURE OF JUDGE		26. SIGNATURE OF SHERIFF	
27. SIGNATURE OF DISTRICT ATTORNEY		28. SIGNATURE OF COUNTY CLERK	
29. SIGNATURE OF STATE CLERK		30. SIGNATURE OF SECRETARY	
31. SIGNATURE OF ASSISTANT SECRETARY		32. SIGNATURE OF CHIEF CLERK	
33. SIGNATURE OF DEPUTY CLERK		34. SIGNATURE OF RECORDS CLERK	
35. SIGNATURE OF FILE CLERK		36. SIGNATURE OF INDEX CLERK	
37. SIGNATURE OF RESEARCH CLERK		38. SIGNATURE OF ASSISTANT RESEARCH CLERK	
39. SIGNATURE OF CLERICAL ASSISTANT		40. SIGNATURE OF OFFICE ASSISTANT	
41. SIGNATURE OF RECEPTIONIST		42. SIGNATURE OF MAIL ROOM CLERK	
43. SIGNATURE OF TELEPHONE ROOM CLERK		44. SIGNATURE OF JANITOR	
45. SIGNATURE OF CLEANER		46. SIGNATURE OF GARDENER	
47. SIGNATURE OF PEON		48. SIGNATURE OF PORTER	
49. SIGNATURE OF MESSENGER		50. SIGNATURE OF DRIVER	
51. SIGNATURE OF TRUCK DRIVER		52. SIGNATURE OF BUS DRIVER	
53. SIGNATURE OF TAXI DRIVER		54. SIGNATURE OF RENTAL CAR DRIVER	
55. SIGNATURE OF AIRLINE PILOT		56. SIGNATURE OF AIRLINE CO-PILOT	
57. SIGNATURE OF AIRLINE ATTENDANT		58. SIGNATURE OF AIRLINE BAGGAGE CLAIM CLERK	
59. SIGNATURE OF AIRLINE TICKET CLERK		60. SIGNATURE OF AIRLINE CATERING CLERK	
61. SIGNATURE OF AIRLINE GROUND CREW		62. SIGNATURE OF AIRLINE PASSENGER	
63. SIGNATURE OF AIRLINE CREW MEMBER		64. SIGNATURE OF AIRLINE PASSENGER	
65. SIGNATURE OF AIRLINE PASSENGER		66. SIGNATURE OF AIRLINE PASSENGER	
67. SIGNATURE OF AIRLINE PASSENGER		68. SIGNATURE OF AIRLINE PASSENGER	
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93. SIGNATURE OF AIRLINE PASSENGER		94. SIGNATURE OF AIRLINE PASSENGER	
95. SIGNATURE OF AIRLINE PASSENGER		96. SIGNATURE OF AIRLINE PASSENGER	
97. SIGNATURE OF AIRLINE PASSENGER		98. SIGNATURE OF AIRLINE PASSENGER	
99. SIGNATURE OF AIRLINE PASSENGER		100. SIGNATURE OF AIRLINE PASSENGER	

RECEIVED
MAY 10 1960
BALTIMORE
STATE DEPARTMENT OF HEALTH
RECORDS SECTION

1760 CERTIFICATE OF DEATH

01762

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		c. LENGTH OF STAY IN 1b <u>424</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>721 I STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Alston</u> Last <u>Wise</u>		4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-1865</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse Children</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Families</u>	11. BIRTHPLACE (State or foreign country) <u>Windsboro, S.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Nathan Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Hannah Barclay</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hattie Ringer 721 I Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-Renal Disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis (General)</u> DUE TO (c) <u>Senility</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 yrs</u> <u>20 yrs?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN. 4, 1958</u> , to <u>February 20, 1960</u> , that I last saw the deceased alive on <u>February 20, 1960</u> , and that death occurred at <u>3 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Wade,</u>		ADDRESS (Street, city or town, state) <u>140 Oak Avenue</u> DATE SIGNED <u>2-20-60</u>	
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		<u>Dundalk 22 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>2-23-60</u>	<u>MT. CALVARY</u>	<u>A. A. COUNTY, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B. Locke, Jr.</u>		ADDRESS <u>1304 N. Central Ave.</u>	
24a. REC'D BY REGISTRAR <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasner</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G255 2-8-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

01763

1770

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 298 Ridge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Zengel		4. DATE OF DEATH Feb 2, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Leffek		14. MOTHER'S MAIDEN NAME Katherine Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Mr. Joseph A. Zengel		Address Box 298 Ridge Rd. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural causes - 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1959 to Feb 2, 1960 that I last saw the deceased alive on January 1960 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leopoldo Gross M.D.		ADDRESS (Street, city or town, state) 201 Ballard Ave Baltimore 20, Md.	
PHYSICIAN'S NAME (Type) Leopoldo Gross M.D.		DATE SIGNED Feb 2, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-5-1960	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Fullerton Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. L. L. Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR FEB 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

01765

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3V01.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnes</u>		c. LENGTH OF STAY IN <u>6 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>3413 Claremont Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Laura E. Ziegenfelder</u>		4. DATE OF DEATH <u>Feb. 15</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16 - 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Kane</u>		14. MOTHER'S MAIDEN NAME <u>Annie Klineyoung</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Andrew Ziegenfelder</u>		Address <u>3413 Ave Claremont</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u> DUE TO <u>Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 2/14</u> , 19 <u>56</u> , to <u>2/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/14</u> , 19 <u>60</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph R. Liberto</u>		ADDRESS (Street, city or town, state) <u>3508 Buck St - Baltimore 24, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH R. LIBERTO</u>		DATE SIGNED <u>2/16/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 18/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herwig Sons Orleans St</u>		24a. REC'D BY REGISTRAR <u> </u> ADDRESS <u>2024</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>FEB 19 1960</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No.

01764

1771

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr10mth12dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Selma Middle Zigmont Last		4. DATE OF DEATH Month February Day 29 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1898
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min. 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Tomoshocokas		14. MOTHER'S MAIDEN NAME Salome Oshenskis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 218-07-6477	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Art. bleer. Cardio Vasc. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 1956 to Feb. 29, 1960 , that I last saw the deceased alive on Feb. 29, 1960 , and that death occurred at 8:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		DATE SIGNED SPRING GROVE STATE HOSPITAL 2-29-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		ADDRESS (Street, city or town, state) Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-MAR-1960	
22c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY		22d. LOCATION (City, town, or county) (State) DUNDALK MD MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Ischaewski		24. REC'D BY REGISTRAR MAR 4 '60	
ADDRESS 637 W. 1st Bldg.		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

